###### PRP REFERRAL FORM

###### DATE OF REFERRAL:

FOR OFFICE USE ONLY

[ ]  **NEW**

[ ]  **REAUTH**

**CLIENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Client’s Name:** | **DOB:**  | **Age:**  |
| **Address:**  | **City:**  | **State:**  | **Zip:**  |
| **Home Phone:**  | **Social Security #:**  | **Medical Assistance #:**

|  |
| --- |
| **Email Address:**  |

 |
| **Please indicate:** |
| **Sex: ☐ Male ☐ Female** | **Ethnicity:** **Religion:** | **Marital Status: ☐ Single ☐ Married ☐ Divorced** |

**Client School:**

**Grade:**

**Number of Arrest in last 30 days?**

**LEGAL CUSTODIAN:**

**Are you the birth parent:** [ ]  **Yes** [ ]  **No (If no please present one of the following documents)**

**IMPORTANT: A LEAGAL DOCUMENT MUST BE PRESENTED AT TIME OF INTAKE TO SHOW GUARDIANSHIP:**

**☐ Court ☐ DSS ☐ Notarized letter stating your guardianship with at least one birth parent signature.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:**  | **Relationship:**  | **Work Phone:**  | **Home Phone:**  |
| **Address:**  | **City:**  | **State:**  | **Zip:**  |

**REFERRAL SOURCE:**

|  |  |  |
| --- | --- | --- |
| **Agency:**  | **Contact Person:**  | **Therapist Name:**  |
| **Email Address:**  | **Phone:**  | **Ext:**  | **Fax:**  |
| **Address:**  | **City:**  | **State:**  | **Zip:**  |

**PRIMARY CARE PROVIDER:**

|  |  |  |
| --- | --- | --- |
| **Facility’s Name:**  | **Doctor’s Name:**  | **Phone:**  |
| **Address:**  | **City:**  | **State:**  | **Zip code:**  |

**DSM-V BEHAVIORAL DIAGNOSIS**

|  |
| --- |
| **DSM-5** |
| **Behavioral**  |
| Diagnostic Category:  | Code:  | Description:  |
| Diagnostic Category:  | Code:  | Description:  |
| Diagnostic Category:  | Code:  | Description:  |
| **Medical** |
| Diagnostic Category:  | Code:  | Description:  |
| Diagnostic Category:  | Code:  | Description:  |
| Diagnostic Category:  | Code:  | Description:  |
| **Social elements Impacting Diagnosis (Check all that apply**) |
| [ ]  **None** | [ ]  **Problems with access to healthcare services**  | [ ]  **Housing problems (not homelessness)** | [ ]  **Problems related to the social environment** |
| [ ]  **Education Problems** | [ ]  **Problems related to interactions with legal system/crime** | [ ]  **Occupational problems** | [ ]  **Homelessness** |
| [ ]  **Financial problems**  | [ ]  **Problems with primary support groups** | [ ]  **Other psychological and environmental problems** | [ ]  **Unknown**  |
| **Functional Assessment**  |
| Date of Diagnosis:  | Assessment Measure/Score: |
| Measure:  |  Name and Title:  |

**PRESENTING COMPLAINT:**

**HISTORY OF PRESENTING PROBLEMS:**

Signature/Title Date