1807 E. Preston Street (Wolfe Street Suite)
Baltimore, MD. 21213
410-276-2123 OR 410-276-2127 (OFFICE) 410-276-4070 (FAX)

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 #:**		
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:				

For Office Use Only:
Date Referral Received: Date Referral Accepted/ Approved:
Intake/Assessment Date: Date Assigned to Coordinator:
Notes:

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	City:

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:	

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"Achieving Your Greatest Self"

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PRESENTING COMPLAINT:

HISTORY OF PRESENTING PROBLEMS:

Signature/Title Date

For Office Use Only:

Date Referral Received: Date Referral Accepted/ Approved:

Intake/Assessment Date: Date Assigned to Coordinator:

Notes: