Dear Mental Health Professional,

Attached is the Referral Form required to receive PRP services from You First Health Systems. The following is required to complete the application process:

- Completed Referral Form
- Medical Records providing a psychosocial and diagnostic summary
- Results of a physical completed within the last year

Please fax the above information to (240) 547-0525. Upon its receipt, I will contact you to schedule an intake appointment. Please feel free to contact me at 301-329-0177 or email info@youfirsthealthsystems.com with any questions. I look forward to working with you.

Sincerely,

You First Health Systems

Intake Coordinator

You First Health Systems

Psychiatric Rehabilitation Program
4325 Forbes Boulevard, Suite E, Lanham, MD 20706
Email: info@youfirsthealthsystems.com
Phone: 301-329-0177
Fax: 240-547-0525

Referral Form
Adult Psychiatric Rehabilitation Program

CLIENT INFORMATION:

Client Name:		**DOB:**		Age:	
Street Address:		**SS #:**		Sex:	☐Male ☐Female
City, State, Zip:		**MA #:**			
Phone #:		**Access to transportation for On Site Activities:**		☐ Yes ☐ No	
Parent/Guardian/ Caregiver Name:		**Relationship:**			
Address (If different)		**Does the Contact Person have Legal custody?**		☐ Yes ☐No	
City, State, Zip		**Phone Number:**			

DSM V DIAGNOSIS: (Must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP)

Behavioral Diagnoses: (*Required*)	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
	Diagnosis Code		Description:	

CLINICAL INFORMATION:

Is the client currently in mental health outpatient or inpatient treatment?	☐Yes ☐No	
Duration of current treatment provided to this individual.	☐Less than one month ☐2-3 months ☐4-6 months	☐7-12 months ☐More than 12 months
Current frequency of treatment provided to individual.	☐At least 1x/ week ☐At least 1x/ 2 weeks ☐At least 1x/ month	☐At least 1x/ 3 months ☐At least 1x/ 6 months
Please indicate which of the following programs the individual is receiving services from:	☐Mobile Treatment/ Assertive Community Treatment (ACT) ☐Inpatient Psychiatric Treatment ☐Residential SUD Treatment Service Level 3.3 ☐Residential SUD Treatment Level 3.5 ☐Residential SUD Treatment Service Level 3.7	☐Mental Health Intensive Outpatient Program (IOP) ☐Mental Health Partial Hospital Program ☐SUD Intensive Outpatient Program (IOP) Level 2.1 ☐SUD Partial Hospitalization Program (PHP) Level 2.2 ☐Residential Crisis

FUNCTIONAL CRITERIA: Medical necessity for admission to Psychiatric Rehabilitation Program services must be documented by the presence of at least **three** of the following on a continuing or intermittent basis.

Evidence of diagnosis impacting marked inability to establish or maintain competitive employment:

Evidence of diagnosis impacting inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management):
Evidence of diagnosis impacting inability to establish/maintain a personal support system:
Evidence of diagnosis impacting concentration/persistence/pace leading to failure to complete task:
Evidence of diagnosis impacting the ability to perform self-care (hygiene, grooming, nutrition, medical care, safety):
Evidence of diagnosis impacting deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities:
Evidence of diagnosis impacting inability to procure financial assistance to support community living

LICENSCED MENTAL HEALTH PROFESSIONAL PROVDIING REFERAL:

Name & Credentials:		**Agency/Organization:**	
Street Address:		**Phone Number:**	
City, State, Zip:		**E-mail Address:**	
Date:	**Signature:**	**Mental Health Treatment currently being Provided:**	☐Outpatient Mental Health Services ☐Inpatient Mental Health Services ☐Residential Treatment Center

SUPERVISING CLINICIAN

Name & Credentials:	
Date:	**Signature:**