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
Minor 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
In the past three months, how many ER visits has the youth had for psychiatric care?	☐ No visits in the last three months ☐One visit in the last three months ☐Two or more visits in the last three months	
Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting?	☐Yes ☐No	
Does the youth have a Targeted Case Management referral or authorization?	☐Yes ☐No	
Has medication been considered for this youth?	☐Not Considered ☐Considered and Ruled Out ☐Initiated and Withdrawn	☐Ongoing ☐Other

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

Evidence of clear, current threat to the youth's ability to be maintained in their customary setting:
Evidence of emerging risk to the safety of the youth or others:
Evidence of significant psychological or social impairments causing serious problems with peers' relationships and/or family members:

What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth' symptoms and functional behavioral impairments resulting from mental illness? (Explain why therapy is not enough and why PRP is needed)
How will PRP server to help this youth get to age-appropriate development, more independent functioning and independent living skills?
Has a crisis plan been completed with family and/or guardian?
☐Yes ☐No
Has an individual treatment plan/Individual rehabilitation plan been completed?
☐Yes ☐No

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:**