

Foundations Psychiatric Rehabilitation Program

1025 West Nursery Road
Suite 118
Linthicum, Maryland 21090
410-789-7772 (office)
443-400-8392 (fax)

Referral Form

Please complete the form in its entirety.

******This form must be completed by a licensed mental health professional******

Services Provided: On and Offsite PRP

Name: _____

Date of Birth: _____ Social Security#: _____

Address: _____

Phone: _____

Referral Source (name and phone #) _____

Emergency Contact Person (name and phone #) _____

Medical Assistance #: _____ Medicare #: _____

Other Insurance (name, address, phone, and group #): _____

Reason for Seeking Services: _____

Diagnosis

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Psychiatrist Name: _____ Phone: _____

******Please note that the person being referred must be connected with a psychiatrist before attempting to enroll in the PRP.******

Therapist Name: _____ **Phone:** _____

Current Medications (psychiatric and somatic): _____

Is the person medication compliant? Yes ___ **No** ___

Is the person able to self-medicate? Yes ___ **No** ___

Are reminders needed to take medication? If so, how often? _____

Who administers/monitors the medication? _____

Where do the medications come from (ex. Pharmacy, doctor's office, etc.)

Most recent hospitalizations (include psychiatric/ somatic, place and date, and reasons for admission): _____

Past Hospital Admissions (include psychiatric/ somatic, place and date, and reasons for admission): _____

Is there a history of substance abuse? If so, explain (include treatment history) _____

Is there any legal and/or criminal history? If so, explain (include any probationary/parole information): _____

Is there a history of violence? If so, explain: _____

Risk Factors (ex: suicidal/homicidal behaviors, elopement, etc.) _____

Please list any significant medical problems: _____

Allergies: _____

Primary Care Physician (name and phone #): _____

Please provide Foundations with any other information that might be helpful in determining services for the person being referred.

Referral Source Signature and credentials: _____

Date: _____

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******Individuals with LGSW or LGPC status are not able to complete the referral per state regulations.******