FIRST CHOICE COUNSELING CENTER
PSYCHIATRIC REHABILITATION PROGRAM
REFERRAL FORM

*****PLEASE INCLUDE ASSESSMENT AND ITP WITH FORM*****
Please fax to 410 779 9400 or email to fccc1@hushmail.com

Consumer Name:	**D.O.B:**	
Guardian Name: _____ **Does the Parent/Guardian have legal custody (if minor)? Yes/ No**		
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell #**	
Medical Assistance/Medicaid #:		
Is the individual eligible for full funding for Developmental Disabilities Administration services? □ **Yes** □ **No**		
Have family or peer supports been successful in supporting this youth? □ **Yes** □ **No**		
Is the primary reason for the youth's impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder □ **Yes** □ **No**		

ICD-10 Primary Diagnosis Code	
Diagnosing Clinician and Title	
Clinician Agency	
Current frequency of treatment provided to this individual □At least 1x/week □ At least 1x/2 weeks □At least 1x/month □ At least 1x/3months □ At least 1x/6months	
How long has youth been engaged in active, documented outpatient treatment? □Less than one month □ 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 setting to the community setting? □ Yes □ No	
Does the youth have a Target 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 □ Not considered □ Considered and Ruled Out □ Initiated and Withdrawn □ Ongoing □ Other Comments:	

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600 Reisterstown Rd Suite 402, Pikesville MD 21208
410 929 4793 (office) 410 779 9400 (fax)

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REFERRAL SOURCE

Agency Name:	Contact Person Name:
Address:	
Phone #:	Fax #:
Email Address:	

Criteria for admission (CHECK ALL THAT APPLY AND COMMENT WHERE CHECKED)	
	A clear, current threat to the individual's ability to be maintained in his/her customary setting
Provide of evidence of clear, current threat to the youth's ability to be maintained in their customary setting:	
	An emerging/pending risk to the safety of the individual or others
Provide evidence of emerging risk to the safety of the youth or others:	
	Significant psychological or social impairments such as inappropriate social behaviors causing serious problems with peer relationships and/or family members
Provide evidence of significant psychological or social impairments causing serious problems with peer 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's symptoms and functional behavioral impairments:	
How will PRP serve to help this youth get to age appropriate development, more independent functioning and independent living skills:	

Licensed Provider Completing this Application:

Print Name: _ _____ Signature_____ Date_____

Revised 7/7/2020

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