FIRST CHOICE COUNSELING CENTER
PSYCHIATRIC REHABILITATION PROGRAM
REFERRAL FORM

*****PLEASE INCLUDE ASSESSMENT AND TREATMENT PLAN 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 #:		
Race:	Ethnicity:	
Marital Status:	Gender:	
Highest Educational Level:	Living Situation:	
Employment Status:	Veteran -Yes/ No, if yes, DATES AND/OR WAR SERVICE _____	

DIAGNOSIS:

Axis I	
Diagnosed by	

REFERRAL SOURCE:

Agency Name	Therapist Name & Credentials
Address:	
Phone Number:	Fax Number:
Email Address:	

First Choice Counseling Center
600 Reisterstown Rd Suite 402 Pikesville MD 21208
410 929 4793 (office) 410 779 9400 (fax)

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CLINICAL INFORMATION

Please include information regarding level of functional impairment:
Skills the participant requested to support his/her recovery:
Skills to be addressed within the first Individualized Recovery Plan:
Participant's identified support systems:
Additional Information (Include client request, preference etc)

PRP Services Requested (check all that apply)

ADULT SERVICES ONLY- Check off services for adult referrals				**YOUTH SERVICES ONLY**- Check off services for youth referrals		
□ Independent Living Skills	□ Social Skills	□ Adaptive Resources		□ Self- Care Skills	□ Social Skills	□ Independent Living Skills
□ Medication Management	□ Employment	□ Education/Vocational Training		□ Conflict Resolution	□ Anger Management	□ Interpersonal Skills
□ Housing	□ Promotion of Wellness	□ Social Relationships/ Leisure Activities		□ Age-Appropriate Boundaries	□ Time Management	□ Maintaining personal safety
□ Self- Care Skills	□ Crisis Intervention	□ Entitlements Assistance		□ Academic Achievement	□ Adaptive Resources	□ Promotion of Wellness

Licensed Provider Completing this Application:

Print Name & Credentials _ _____
Signature_____
Date_____

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