LINMAR LEADERSHIP

PSYCHIATRIC REHABILITATION PROGRAM REFERRAL FOR SERVICES

To efficiently process referrals, please fill out this form in its entirety, sign and date.

PLEASE EMAIL THIS FORM ALONG WITH THE MOST RECENT TREATMENT PLAN TO LINMARLEADERSHIP@GMAIL.COM

Medical Necessity Criteria*: To ensure that clients being referred to PRP services meet the medical necessity criteria as defined by COMAR we must document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.*

Referral Source Information:	
Date of Referral:	Referring Agency:
Treating Provider Name, Title & Credentials:	
Treating Phone:	Treating Email Address:

Demographic Information:				
Client Name				
Date of Birth:	Age:	SS#:	MA#	Gender Preference:
Ethnicity/Race		Primary Language:		
Marital Status	☐Single ☐ Married ☐ Divorced ☐Separated ☐ Widow ☐ Partnered			
Veteran	☐Yes ☐No	If yes, what is the year of discharge?		
Current Address	☐ Check here if Homeless	If homeless, how long?		
	Full Address, City, State, Zip Code:			
Contact Numbers	Home:	Cell:	Email Address:	
Guardian(s)			Phone:	
Primary Care Physician		Phone:	Fax:	
Accommodations	☐ TTY ☐ Interpreter ☐ Sign language ☐ Ambulatory limitations ☐ None ☐ Other:			
Legal Status	☐ Adopted ☐ Parent is legal guardian ☐ Committed to DSS Custody ☐ Arrested within the last 30 days?			
Receiving SSI or SSDI?	☐ Yes ☐ No ☐ Other (Please explain):			
Employment Status	Currently? ☐ Yes ☐ No ☐ Not Applicable ☐ Seeking Employment If so, where,			
Educational Status	Currently enrolled? ☐ Yes ☐ No Highest Grade Completed: Current School Name (if minor):			

Rehabilitation Services Requested:									
☐	Dietary Planning	☐	Maintain Personal Living Space	☐	Age-Appropriate Self-Care Skills	☐	Community Integration Activities	☐	Age-Appropriate Boundaries
☐	Self-Administration of Medication	☐	Maintain Personal Safety	☐	Social Skills/Peer Interaction	☐	Physical Health	☐	Anger Management Conflict Resolution
☐	Grooming	☐	Family Natural Support Issues	☐	Coping Skills	☐	Mindful Coping Strategies	☐	Assertiveness/Self-Esteem
☐	Developing Natural Supports	☐	Interaction with Peers/Authority Figures	☐	Health Promotion & Training	☐	Community Awareness/Advocacy	☐	Time Management
☐	Individual Wellness Self-Management and Recovery	☐	Facilitating transition from more intensive services	☐	School Performance Issues	☐	Interpersonal Communication Skills	☐	Access Entitlements

Current Treatment: Please list agency, type of treatment, duration of treatment, frequency of treatment, and party responsible for current inpatient and outpatient therapeutic services.

Agency Name	Type of Treatment	Duration of Treatment	Frequency of Treatment	Responsible Party
		☐ Less than a month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ more than 12 months	☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3months ☐ At least 1x/6 months	
		☐ Less than a month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ more than 12 months	☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3months ☐ At least 1x/6 months	
		☐ Less than a month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ more than 12 months	☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3months ☐ At least 1x/6 months	
		☐ Less than a month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ more than 12 months	☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3months ☐ At least 1x/6 months	

Current Medication: ☐ Client is not currently taking medication

Name of Medication	Dosage	Frequency

PLEASE NOTE: THIS PAGE MUST BE COMPLETED FOR ALL ADULT REFERRALS

Diagnosis: Please indicate current DSM diagnosis **(MUST HAVE ICD-10 Code)** **ADULTS MUST HAVE ONE OF THE FOLLOWING DIAGNOSIS FOR PRP ELIGIBILITY CONVERTED TO ICD 10 CODE**	
295.90/F20.9 Schizophrenia 295.40/F20.81 Schizophreniform Disorder 295.70/F25.0 Schizoaffective Disorder, Bipolar Type 295.70/F25.1 Schizoaffective Disorder, Depressive Type 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic D/O 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder 297.1/F22 Delusional Disorder 296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe 296.34/F33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features 301.22/F21 Schizotypal Personality Disorder	296.43/F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe 296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic Psychotic Features 296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe 296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features 296.40/F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic 296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified 296.7/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified 296.80/F31.9 Unspecified Bipolar and Related Disorder 296.89/F31.81 Bipolar II Disorder 301.83F60.3 Borderline Personality Disorder
PRIMARY ICD 10 CODE:	PRIMARY DSM V CODE:
ICD 10 CODE:	DSM V CODE:

PER MEDICAL NECESSITY CRITERIA, AT LEAST THREE OF THE FOLLOWING MUST BE PRESENT ON A CONTINUING OR INTERMITTENT BASIS OVER THE PAST TWO YEARS. CHECK ALL THAT APPLY.

Functional Impairment Areas *(The impairment as a result of the participant's mental illness)*	YES	NO
Marked inability to establish or maintain competitive employment		
Marked inability to perform instrumental activities of daily living (eg. shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)		
Marked inability to establish/maintain a personal support system.		
Deficiencies of concentration/persistence/pace leading to failure to complete tasks		
Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)		
Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities.		
Based on the functional impairment areas identified above, please provide clinical evidence of marked inability and justification for PRP services using medical necessity criteria* (see top of page 1). Please be concise.		

Upon the clinician's signature below, the client being referred is appropriate for psychiatric rehabilitation program services and is currently in therapy with my organization. This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)

Print Clinicians Name:	*Credentials:*
Clinicians Signature:	*Date:*

PLEASE NOTE: THIS PAGE MUST BE COMPLETED FOR ALL MINOR REFERRALS

Diagnosis: Please indicate primary DSM diagnosis **(MUST HAVE ICD-10 Code)** **Per COMAR this must be a Public Behavioral Health System (PBHS) speciality mental health diagnosis. For a list of valid diagnosis see:** **https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/resources/PMHS%20Mental%20Health%20Diagnosis%20Codes%20ICD%20updated%2012-13-18.pdf**	
PRIMARY ICD 10 CODE:	PRIMARY DSM V CODE:
ICD 10 CODE:	DSM V CODE:

PER MEDICAL NECESSITY CRITERIA, IMPAIRMENT & EMOTIONAL DISTURBANCE MUST BE PRESENT WITHIN THE PAST 3 MONTHS AND RESULT IN ONE OF THE FOLLOWING AREAS. CHECK ALL THAT APPLY.

Functional Impairment Areas *(The impairment as a result of the participant's mental illness)*	YES	NO
A clear, current threat to the youth's ability to be maintained in their customary setting.		
An emerging risk to the safety of youth or others.		
Significant psychological or social impairments causing serious problems with peer relationships and/or family members.		
Based on the functional impairment areas identified above, please provide clinical evidence of emotional disturbance and justification for PRP services using medical necessity criteria* (see top of page 1). Please be concise.		
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 resulting from mental illness?		

Upon the clinician's signature below, the client being referred is appropriate for psychiatric rehabilitation program services and is currently in therapy with my organization. This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)

Print Clinicians Name:	*Credentials:*
Clinicians Signature:	*Date:*