BALTIMORE COUNTY
5820 York Ave
Suite 202
Baltimore, MD 21212
301-345-1022 x7046

CARROLL COUNTY
532 Baltimore Blvd
Suite 403
Westminster, MD 21157
301-345-1022 x7045

FREDERICK COUNTY
1003 West 7th Street
Suite 205
Frederick, MD 21701
301-345-1022 x7045

MONTGOMERY COUNTY
16220 Frederick Road
Suite 310
Gaithersburg, MD 20877
301-345-1022 x7021

PRINCE GEORGE'S COUNTY
7474 Greenway Center Drive
Suite 730
Greenbelt, MD 20770
301-345-1022 x7050

Advanced Behavioral Health
Greater Maryland Adult and Youth Program
Referral for Psychiatric Rehabilitation Program (PRP) Services

Referral Date: _____ **Referral Source (Name, Credentials, Phone Number):** _____

Source of Referral (check one): ☐ **Therapist** ☐ **Psychiatrist** ☐ **Other:** _____

Client Name: _____ **Date of Birth:** _____ **Sex:** _____

Ethnicity: _____ **Primary Language:** _____

Client Full Address: _____

Guardian Name and Telephone Number: _____

Client Medical Assistance Number (11 digits): _____ **Client Diagnosis:** _____

Current School: _____ **Grade:** _____

Current Outpatient Provider: _____

Frequency of treatment is at least: ☐ 1x/week ☐1x/2 weeks ☐ 1x/month ☐ 1x/3 months ☐ 1x/6 months

Length of outpatient treatment: ☐ < 1 month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ > 12 months

In the last 3 months, how many ER visits has the youth had for psychiatric care? ☐ 0 ☐ 1 ☐ 2+

Is the youth transitioning from inpatient, day hospital, or residential treatment setting? ☐ Yes ☐ No

Does the youth have a Targeted Case Management Referral or Authorization? ☐ Yes ☐ No

Has medication been considered?

☐Not Considered ☐Considered & Ruled Out ☐Initiated & Withdrawn ☐Ongoing ☐Other: _____

Please select the youth's current areas of need below:

BEHAVIORAL IMPAIRMENTS:				
☐Suspensions/detention/calls Home	☐Oppositional behaviors	☐Isolative behaviors	☐Poor independent living skills	☐Verbal/ physical aggression
☐School refusal/Attendance issues/ Poor academic performance	☐Severe impulsivity/ ADHD symptoms	☐Poor anger management	☐Recent hospitalization	☐Poor coping skills
☐Poor hygiene/self-care skills	☐Treatment noncompliance	☐Other:		
RISK OF SAFETY TO YOUTH AND OTHERS:				
☐Aggressive behaviors	☐SI/HI/self-harm	☐Poor anger management	☐Recent Arrest/DJS involvement	☐Abuse/Neglect/ CPS involvement
☐Severe Impulsivity	☐Running away/elopement	☐Recent hospitalization	☐Other:	
SOCIAL IMPAIRMENTS:				
☐Poor communication skills	☐Poor social skills	☐Peer conflict	☐Family conflict	☐Poor anger management
☐Lack of social or family support	☐Social isolation	☐Other:		

Please explain above impairments in detail:

_____

_____

_____

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Referral Source Signature (Please include credentials) **Date**

If referral source is LMSW/LGPC, Name and Credentials of Clinical Supervisor:

_____