

ALLOVER HEALTHCARE OUTPATIENT MENTAL HEALTH CLINIC REFERRAL FORM

Referral Source Information

Agency/Individual Name: _____ Phone #: _____

Address: _____ Fax #: _____

EMAIL ADDRESS: _____

Referring Individual Credentials: _____ Referring Individual Signature: _____

Location: 5450 Reisterstown Road STE 304 Baltimore, MD 21215 Phone: 443-759-8827 Fax: 443-759-8870

Email: info@alloverhealthcaregroup.com Website: www.alloverhealthcaregroup.com

DATE OF REFERRAL: _____

Client Information

Client Name: _____ Date of Birth: _____ Gender: Male Female

Parent/ Legal Guardian Name: _____ Foster Parent: Yes No (if yes submit copy of court order)

Age: _____ MA #: _____ MCO: _____ Social Security #: _____

Ethnicity: _____ Is there a current or previous substance use? Yes No If yes, currently in treatment? Yes No

Home Address: _____ Is the client Homeless? Yes No

Best Number to Contact: _____ email address: _____

Services Requested

<input type="checkbox"/> Mental Health Evaluation/Assessment	<input type="checkbox"/> Psychiatric Rehabilitation Services/ PRP
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Substance Abuse Services: (circle one) Counseling, DUI/DWI Groups
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Adult Targeted Case Management
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Psychiatric Services/ Medication Evaluation

Reason for Referral/Presenting Problems (PLEASE BE SPECIFIC)

Is the client currently on psychotropic medications? _____yes _____no

If yes, please list all medications _____

➤ Has the client recently been discharged from an outpatient Mental Health Facility/ Hospital: Yes No
(If yes, have they provided a copy of the aftercare plan?): Yes No

➤ Has the client been arrested in the past six months? Yes No If Yes, How many times? _____

➤ Is the client a veteran? Yes No

➤ Currently enrolled in educational program? Yes No **Highest Grade Completed** _____
School Name: _____

➤ Currently Employed? Yes No

Office Use Only

Insurance Authorization Number _____ Number of Auth. Visits: _____

Dates of Authorization From: _____ To: _____

Scheduled Diagnostic Interview Yes No Date: _____ Therapist: _____

Immunization Record Request Yes No Date: _____

Date Assigned/Comments: _____

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COMPLETE FOR PRP SERVICES REQUESTS ONLY:

Diagnosis: please indicate current DSM diagnoses. (MUST HAVE AXIS I DIAGNOSIS)
ADULTS MUST HAVE ONE OF THE FOLLOWING DIAGNOSIS FOR PRP ELIGIBILITY

<input type="checkbox"/> F20.9 Schizophrenia	<input type="checkbox"/> F31.13 Bipolar I, Most Recent Manic, Severe
<input type="checkbox"/> F20.81 Schizophreniform Disorder	<input type="checkbox"/> F31.4 Bipolar I, Most Recent Depressed, Severe
<input type="checkbox"/> F25.1 Schizoaffective Disorder, Depressive	<input type="checkbox"/> F31.0 Bipolar I, Most Recent Hypomanic
<input type="checkbox"/> F29 Unspecified Schizophrenia Spectrum & other Psychotic Disorder	<input type="checkbox"/> F31.9 Bipolar I Disorder, Unspecified
<input type="checkbox"/> F25.0 Schizoaffective Disorder, Bipolar Type	<input type="checkbox"/> F31.2 Bipolar I, Most Recent Manic, with Psychosis
<input type="checkbox"/> F28 Other specified Schizophrenia Spectrum and other Psychotic Disorder	<input type="checkbox"/> F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis
<input type="checkbox"/> 297.1/ F22 Delusional Disorder	<input type="checkbox"/> F31.9 Bipolar I, Most Recent Hypomnic, Unspecified
<input type="checkbox"/> F33.2 MDD, Recurrent Episode, Severe	<input type="checkbox"/> F31.81 Bipolar II Disorder
<input type="checkbox"/> F33.3 MDD, Recurrent, With Psychotic Features	<input type="checkbox"/> F60.3 Borderline Personality Disorder
	<input type="checkbox"/> F21 Schizotypal Personality Disorder
	<input type="checkbox"/> F31.9 Unspecified Bipolar Disorder

PLEASE USE ICD-10 CODE

Axis I: ICD CODE:

Diagnosis given by:

PLEASE COMPLETE FOR PRP AND TARGETED CASE MANAGEMENT REQUESTS

Rehabilitation Services Needed:

- Activities of Daily Living Safety to Self/Others Vocational Skills
- Anger/Temper/Conflict Resolution School Performance Leisure Skills
- Assertiveness/Self-esteem Sexual Issues Work/Job Performance
- Community Activity Social Skills/Peer Interaction Legal Issues (# of arrests?)
- Family/Natural Supports Substance Abuse Issues Money Management
- Finances Coping Skills Dietary/Food Preparation
- Home/Housing Trauma Crisis Management Skills
- Self Care Skills Medication Compliance Skills Physical Health

History of Challenges and Rehabilitation Needs:

In Current Treatment?

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1. Therapist Name and Phone Number: _____
2. Psychiatrist Name and Phone Number: _____

Office Use Only

Insurance Authorization Number _____ Number of Auth. Visits: _____

Dates of Authorization From: _____ To: _____

Scheduled Diagnostic Interview Yes No Date: _____ Therapist: _____

Immunization Record Request Yes No Date: _____

Date Assigned/Comments: _____