Allover Healthcare Group™
Healthcare | Technology | Education Solutions

ALLOVER HEALTHCARE OUTPATIENT MENTAL HEALTH CLINIC REFERRAL FORM

Referral Source Information

Agency/Individual Name: _____ Phone #: _____

Address: _____ Fax #: _____

EMAIL ADDRESS: _____

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

❑ Mental Health Evaluation/Assessment	❑ Psychiatric Rehabilitation Services/ PRP
❑ Individual Therapy	❑ Substance Abuse Services: (circle one) Counseling, DUI/DWI Groups
❑ Group Therapy	❑ Adult Targeted Case Management
❑ Family Therapy	❑ 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 DIAGOSIS FOR PRP ELIGIBILITY**

295.90 Schizophrenia	296.43 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
295.40 Schizophreniform Disorder	296.44 Bipolar I Disorder, Current or Most Recent Episode Manic Psychotic Features
295.70 Schizoaffective Disorder, Bipolar Type	296.53 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
295.70 Schizoaffective Disorder, Depressive Type	296.54 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
298.8 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	296.40 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
298.9 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	296.40 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
297.1 Delusional Disorder	296.7 Bipolar I Disorder, Current or Most Recent Episode Unspecified
296.33Major Depressive Disorder, Recurrent Episode, Severe	296.80 Unspecified Bipolar and Related Disorder
296.34 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features	296.89 Bipolar II Disorder
301.22 Schizotypal Personality Disorder	301.83 Borderline Personality 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?

1. **Therapist 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:_____

ALLOVER HEALTHCARE OUTPATIENT MENTAL HEALTH CLINIC REFERRAL FORM

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:_____