



REFERRAL FORM
Psychiatric Rehabilitation Program
1398 Lambertson Drive, Suite 3
Silver Spring, MD 20902
(301) 754-1102 FAX (301) 754-1690
www.thresholdservices.org

Date ____/____/____

Referral to: (PLEASE CHECK OFF THE APPROPRIATE SITE FOR REFERRAL)

- | | |
|---|-----------------------|
| Bel Pre Outreach (Aspen Hill, Olney, Gaithersburg) | _____ Pamela Miller |
| Halpine Outreach (Rockville, North Bethesda) | _____ Ralf Schneider |
| IDDT Outreach (Substance Use, Silver Spring, Wheaton, Bethesda, Takoma Park) | _____ Betsy Bowman |
| Paint Branch Outreach (Takoma Park, Bethesda, Chevy Chase) | _____ Nancy Sushinsky |
| Renaissance Day Program | _____ Esther Brunner |
| Renaissance Outreach (Silver Spring, Wheaton) | _____ Esther Brunner |

Referring Person and/or Agency _____ Phone _____

Who should be contacted to schedule the intake assessment? _____

Client's Name _____ SS# _____ - _____ - _____

Address _____

Phone (_____) _____ - _____ D.O.B _____/_____/_____ Age _____

Race _____ Sex _____

Medicare # _____ Effective Date _____

Medical Assistance # _____ Effective Date _____

Other Insurance # _____

Marital Status: () Single () Married () Separated () Divorced

Number of Children _____

Housing Status: _____

Do you drive? _____ Do you use public transportation? _____

SOURCE OF INCOME

Parents _____ Spouse _____ Self _____ SSI/SSDI _____

Public Assistance _____ Unemployment _____

Other (Savings, Retirement, etc.) _____

TOTAL MONTHLY INCOME: \$ _____ Who is the rep payee? _____

EDUCATION/EMPLOYMENT

High School _____ Diploma: Yes ___ No___

College _____ Diploma: Yes ___ No ___

Course of Study/Major: _____

Additional Education/Training: _____

Work History (positions, dates, whether volunteer or paid) _____

EMERGENCY CONTACTS

Name _____ Relationship _____

Address _____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Medical Physician _____ Phone (_____) _____ - _____

Address _____

Psychiatric Physician _____ Phone (_____) _____ - _____

Address _____

Primary Therapist _____ Phone (_____) _____ - _____

Address _____

DIAGNOSTIC IMPRESSIONS: (Use DSM designation & number)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V - GAF _____

Date or age of onset of disability _____

History of psychiatric hospitalizations. Include dates, hospital (public/private/general), reasons, length of stay.

Describe behavior and/or symptoms, which indicate decompensation:

Describe history of criminal records and/or violence/aggression: () N/A _____

History of suicidal ideation: () N/A _____

History of Substance abuse: () N/A _____

Physical condition/disabilities: () N/A (Include visual/auditory/physical/somatic) _____

Known allergies: () N/A _____

Other current agency involvement (PRP, DVR, M.H.A., DOCR, Social Workers, etc.): Include names and phone numbers.

Previous Day Program(s) () N/A (include reason for leaving) _____

What are the goals for PRP services? Why is the client being referred? (i.e. structure, socialization, employment support, medication monitoring, travel training, ADL support, case management, etc.) _____

Client's strengths and interests: (please list) _____

Client's weaknesses: (please list) _____

Medications (name, dosage, and monitoring needs). _____

Referring agent's Signature (Must be a mental health professional)

Date

Client's Signature

Date