



435 Eastern Boulevard, Essex, MD 21221

Tel: 443-596-8238 Fax: 443-460-6855

Referral Form

Please complete both pages of this form, sign and date, and email to info@sabinashouse.com or fax to 443-460-6855

Date: _____ Consumer Name: _____

SS#: _____ - _____ - _____ DOB: _____ / _____ / _____ Sex: _____ Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone (Home): _____ (Work/Mobile): _____

Physical Description: _____ Highest Grade Completed: _____

Emergency Contact (Relationship to Consumer): _____

Contact's Phone (Home): _____ (Work/Mobile): _____ Support for Client? Yes No

Current consumer status (please indicate to assist in the prioritization of referrals):

- Inpatient- projected release date: _____
- Partial Hospitalization- projected release date: _____
- Crisis Bed/Other crisis facility- projected release date: _____
- Outpatient
- Date of most recent inpatient discharge: _____
- Other: _____

DSM 5 Behavioral Diagnoses:

Code(s)

Priority Pop. DSM-5 / ICD-10 Behavioral Diagnosis: (Client must have one of the following diagnoses as primary to qualify for PRP services)

- 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 or Other Psychotic Disorder
- 298.9/F29 Unspecified Schizophrenia Spectrum of 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, Severe with Psychotic Features
- 296.43/F31.13 Bipolar Disorder, Current or most Recent Episode Manic, Severe
- 296.44/F31.2 Bipolar I Disorder, Current or most Recent Episode Manic, Severe, with Psychotic Features
- 296.53/F31.4 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe
- 296.54/F31.5 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe with Psychotic Features
- 296.40/F31.0 Bipolar I Disorder, Current or most Recent Episode Hypomanic
- 296.7/F31.9 Bipolar I Disorder, Unspecified
- 296.80/F31.9 Unspecified Bipolar and Related Disorder
- 296.89/F31.81 Bipolar I Disorder,
- 301.22/F21 Schizotypal Personality Disorder
- 301.83/F60.3 Borderline Personality Disorder

Additional Behavioral Health Diagnosis: _____

(please complete page 2)

Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Problems with access to healthcare services | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Housing problems (Not Homelessness) | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Problems related to social environment | <input type="checkbox"/> Problems with primary support group |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Other psychosocial and environmental problems |
| <input type="checkbox"/> Problems related to interaction w/legal system/crime | <input type="checkbox"/> Unknown |

Functional Assessment: _____

Definition of Problem Areas (Current Symptoms): _____

Reason(s) for seeking treatment (check all that apply):

- Linkage to community resources/community integration
- Facilitating transition from more intensive services
- Prevention/reduction of hospitalization or rehospitalization
- Coordination of current community services
- Other: _____

Risk for Aggressive Behaviors, Suicide, or Homicide: (explain): _____

Entitlement Information:

SSI monthly: \$ _____ Date Active: _____

SSDI monthly: \$ _____ Date Active: _____

Medicaid #: _____ Date Applied / Active _____

Other Income/Insurance: _____

If consumer does NOT have medical assistance/Medicaid, he or she must meet one or more of the following criteria to qualify for services through Uninsured Eligibility Coverage:

- Currently homeless or at risk for homelessness
- Has had an inpatient hospitalization within the last three (3) months
- Has been incarcerated within the last three (3) months

Upon the clinician's signature below, the client being referred is appropriate for psychiatric rehabilitation program services provided by Sabinas House. This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)

I, _____, refer _____

(Clinician's Signature)

(Print Consumer's Name)

(Print Clinician's Name and Credentials)

(Clinician's Phone Number)