New Vison Behavioral Health Services, Inc

**Adults** PRP Referral Form

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Referral  |  | Initial referral | **☐** | Concurrent referral | **☐** |

Referral Source Information

|  |  |
| --- | --- |
| Name and Credentials |  |
| Supervisor and Credentials(If applicable) |  |
| Agency |   | **☐** NVBHS |

Participant Information

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | MA # |  |
| Social Security # |  | DOB |  | Age |  | Gender |  |
| Address |  | City, State, Zip |  |
| Cell # |  | Alternative # |  |
| Race | **☐AfrAmer/Black ☐Cauca/White ☐Hispanic ☐Asian ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Ethnicity | **☐ Hispanic** | **☐ non-Hispanic** |

Qualifying Diagnosis (Please check at least one)

|  |
| --- |
| Category A |
| **☐ F20.0 Paranoid Schizophrenia** | **☐ F25.8 Other Schizoaffective** |
| **☐ F20.1 Disorganized Schizophrenia** | **☐ F25.9 Schizoaffective, unspecified** |
| **☐ F20.2 Catatonic Schizophrenia** | **☐ F22 Delusional disorder** |
| **☐ F20.3 Undifferentiated Schizophrenia** | **☐ F28 Other psychotic disorder** |
| **☐ F20.5 Residual Schizophrenia** | **☐ F29 Unspecified psychosis** |
| **☐ F20.81 Schizophreniform Disorder**  | **☐ F31.2 Bipolar I, manic severe w/psych ft** |
| **☐ F20.89 Other Schizophrenia** | **☐ F31.5 Bipolar I d/o depress sev w/psych ft** |
| **☐ F20.9 Schizophrenia, unspecified** | **☐ F31.64 Bipolar I d/o mix sev w/psych ft** |
| **☐ F25.0 Schizoaffective, bipolar** | **☐ F33.3 MMD, recurrent sev w/psych ft** |
| **☐ F25.1 Schizoaffective, depressive** | **☐ Other** |
| Category B |
| **☐ F31.0 Bipolar I disorder, hypomanic** | **☐ F31.81 Bipolar II disorder** |
| **☐ F31.13 Bipolar I, manic severe** | **☐ F31.9 Bipolar disorder, unspecified** |
| **☐ F31.4 Bipolar I, depressed severe** | **☐ F33.2 MMD, Recur, severe w/o psych ft** |
| **☐ F31.63 Bipolar d/o, mix severe w/o psych** | **☐ F60.3 Borderline personality disorder** |

Duration of current episode of treatment provided for the participant:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **☐ < 1 month** | **☐ 2-3 months** | **☐ 4-6 months** | **☐ 7-12 months** | **☐ 12 months or >** |

Frequency of treatment provided to this individual:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **☐ 1x/week** | **☐ 2x/week**  | **☐ 1x/month** | **☐ 3x/month** | **☐ 1x/6 months** |

Receiving SSI or SSDI ☐ No ☐ Yes (If yes, attach a Copy with referral) ☐ Unknown.

**Functional Criteria:**

If the impairments have been for at least 2 years, check **at least 3 criteria** below, if apply:

**☐** Marked inability to establish/maintain independent competitive employment

**☐** Marked inability to perform instrumental activities of daily living (shopping house chores, meal prep, medication management, money management)

**☐** Marked inability to establish or maintain personal support system

**☐** Marked or frequency deficiencies of concentration, persistence, or pace

**☐** Marked inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, personal safety)

**☐** Marked deficiencies in self-direction

**☐** Marked inability to procure financial assistance to support community living

**Social Elements Impacting the Diagnosis**

|  |  |  |  |
| --- | --- | --- | --- |
| **☐ Housing/Homelessness**  | **☐ Legal/Crime** | **☐ Health Care** | **☐ Social Environment** |
| **☐ Education/Vocational** | **☐ Financial** | **☐ Primary Support** | **☐ Psych Environment** |

|  |
| --- |
| **Clinical Assessment** |
| ***Please add a brief summary of the Functional criteria* Selected Above, *including symptoms and functional impairments***  |
|  |

Referring Clinician Signature: Date