Paragon Rehabilitation Program Referral

1116 Reisterstown Rd Suite 201
Pikesville MD 21208
Phone: 410-759-4777
www.paragonprp.com

To efficiently process referrals, please fill out this form in its entirety, sign and date.

Demographics

Date: _____/_____/_______ Consumer's Name: ____

Social Security: _____-____-____ DOB: _____/______/______ Gender: ___________________ Race:_______________

Street Address: ____

City: ____________________________ State: _____ Zip Code: ________________

Consumer's Phone Number:______-_____-___________ Highest Grade Completed: _______________________

Emergency Contact Name and Relationship to Consumer: ____
Contact's Phone Number: ______-______-________

Current Consumer Status (please indicate to assist in the prioritization of referrals):

☐ Outpatient

☐ Date of most recent inpatient discharge:_________________________________

☐ Inpatient-project release date: ___________________

☐ Partial Hospitalization- projection release date: _______________

☐ Criss Bed/Other Criss Facility-projected release date:____________

☐ Other: _____________

Reason(s) For Seeking Treatment (check all that apply):

☐Linkage to community resources/community integrations

☐Prevention/reduction of hospitalization or rehospitalization

☐Facilitating transition from more intensive services

☐Coordination of current community services

DSM 5/IC-10 Diagnosis

Priority Diagnosis: ____

Date of Diagnosis: __________

Additional Behavioral Health Diagnosis: ____

Definition of Problem Areas (Current Symptoms): ____

____

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

____

Social Elements Impacting Diagnosis (check all that apply):

☐None

☐Problems with access to health Services

☐Housing problems (including homelessness)

☐Problems related to social environment

☐Educational problems

☐Problems related to interaction w/ legal system/crime

☐Occupational problems

☐Medication management problems

☐Financial problems

☐Problems with primary support group

☐Other psychosocial and environmental problems

☐Unknown

Entitlement Information:

SSI Monthly: ________________________________ Date Active: ______________________________________

SSDI Monthly: _______________________________ Date Active: ______________________________________

Medicaid #__________________________________ Date Applied/Active________________________________

Other Income/Insurance____

Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided by Paragon. 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)

Referring Agency: ____

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