Paragon Psychiatric Rehabilitation Program Referral

Demographics

Consumer's Name: _____ **Date of Referral:** ____/____/____

DOB: ____/____/____ **Gender:** _____ **Race:** _____ **Martial Status:** _____
Home Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Social Security_____-_____-_____ **Medical Assistance #** _____

Consumer's Phone Number: _____-_____-_____ **Highest level of Education:** _____
Consumer's Email Address: _____ **Employment Status:** _____

Emergency Contact Name and Relationship to Consumer: _____
Contact's Phone Number _____ ____

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

Presenting Issues: (include specific symptoms, ER visits and other crisis interventions)

_____

_____

DSM 5/IC-10 Diagnosis- Priority Population Disorder

☐ 295.90/F20.9 Schizophrenia
☐ 296.53/ F31. 4 Bipolar I, Most Recent Depressed, Severe
☐ 295.40/F20.81 Schizophreniform Disorder
☐ 296.40/ F31. 0 Bipolar I, Most Recent Hypomanic
☐ 295.70/F25.1 Schizoaffective Disorder, Depressed Type
☐ 296.7/ F31. 9 Bipolar I Disorder, Unspecified
☐ 298.90/F29 Unspecified Schizophrenia Spectrum/ Psychotic Disorder
☐ 296.44/ F31. 2 Bipolar I, Most Recent Manic, with Psychosis
☐ 295.70/F25.0 Schizoaffective Disorder Bipolar Type
☐ 296.54/ F31. 5 Bipolar I, Most Recent Depressed, w/o Psychosis
☐ 298.8/F28 Other Specified Schizophrenia Spectrum/Psychotic Disorder
☐ 296.40/F31.9 Bipolar I, Most Recent Hypomanic, Unspecified
☐ 297.1/F22 Delusional Disorder
☐ 296.89/F31.81 Bipolar II Disorder
☐ 296.33/ F33.2 MDD, Recurrent Episode/Severe
☐ 301.83/F60.3 Borderline Personality Disorder
☐ 296.34/F33.3 MDD, Recurrent, With Psychotic Features
☐ 301.22/ F21 Schizotypal Personality Disorder
☐ 296.43/ F31.13 Bipolar 1, Most Recent Manic, Severe
☐ 296.80/F31.9 Unspecified Bipolar Disorder

Social Elements Impacting Diagnosis (check all that apply):

☐ Employment
☐ Occupational problems
☐ Problems with access to health Services
☐ Medication management problems

Paragon PRP

Consumer Name_____ Date of Birth_____

☐ Housing problems (including homelessness)

☐ Problems related to social environment

☐ Educational/Vocational Training

☐ Financial problems

☐ Problems with primary support group

☐ Anger Management

Consumer Experiences at least <u>three</u> of the following:

☐ Inability to maintain independent employment

☐ Severe inability to perform executive functioning skills

☐ Severe inability to establish or maintain social supports

☐ Need or assistance with basic living skills

☐ Unable to perform self-care

☐ Deficiencies of concentration/failure to complete tasks

Duration of Impairment (s):

☐ Marked functional impairment has been present for less than 2 years
☐ Marked functional impairment has been limited to less than 3 of the above listed areas
☐ Has demonstrated marked impaired functioning primarily due to a mental illness in at least 3 of the areas listed above at least 2 years
☐ Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years

Referring Therapist Information

Referring Clinician name and Credential _____
Agency's Name and Address: _____
Agency's fax number:_____
Clinician's email address: _____

Is Consumer currently receiving mental health treatment from a licensed mental health professional _____Yes _____No
Has the individual received PRP services from at least one other PRP within the past year? _____Yes _____No

What is the duration of current episode of treatment provided to this Consumer?

Less than a month	☐	1-2 months	☐	2-3 months	☐
4-6 months	☐	7-12 months	☐	More than 12 months	☐

Current Frequency of treatment provided to this Consumer:

At least 1x/week	☐	At least 1x/2 weeks	☐	At least 1x/month	☐
At least 1x/3months	☐	At least 1x/6months	☐		

List specific Ways in which PRP services are expected to help this Consumer: _____

_____

Mental Health Practitioner Completing Referral:
Print Name and Credentials: _____ Date: _____
Signature: _____ Date:

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