TIDEMARK BEHAVIORAL HEALTH

7822 Eastern Ave. Baltimore, MD 21224 I info@tidemarkinterventions.com I 1.800.847.6028

�� Child & Adolescent PRP Referral Form ��

Date of Referral :____________________

Medicaid #:	

Name:		**Date of Birth:**		**Gender:** ❑ Male ❑ Female ❑ ____________________
Phone #:		**Email:**		
Address:				

Does the Minor speak English without assistance? ❑ No ❑ Yes **Does the Minor speak another language?** ❑ No ❑ Yes

Risk Level: * *Is there a* ❑ *Sexual Offender or* ❑ *Domestic Violence in the home?* ❑ *No*

❑ Suicidal Ideation ❑ Suicidal Plan ❑ Previous Suicide Attempt ❑ Homicidal Ideation ❑ Homicidal plan

Clinical Information:	
The client has been engaging in active, documented, outpatient treatment in total for: ______ years ______ months	**Psychiatric hospitalization in the last 6 months?** ❑ No ❑ Yes- Dates: ______________________
Duration of *current* episode of treatment provided:	**Current frequency of treatment:**

Medical Diagnosis: Per COMAR this must be a Public Behavioral Health System (PBHS) specialty mental health diagnosis. *(Please use ICD-10 & Diagnosis Description)*	
Diagnosis:	

Presenting Symptoms: *(Please include history of SI and HI)*

7822 Eastern Ave. Baltimore, MD 21224 I info@tidemarkinterventions.com I 1.800.847.6028

Has medication been considered for this Minor?: *(Please attach Medication Log & ITP)*

❑ NOT Considered ❑ Considered & Ruled Out ❑ Initiated & Withdrawn ❑ Ongoing ❑ Other (Please Explain):

____

1. **Is the participant eligible for fully funded Developmental Disabilities Administration services?** ❑ No ❑ Yes
2. **Have family or peer supporters been successful in supporting this youth?** ❑ No ❑ Yes
3. **Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder?** ❑ No ❑ Yes
4. **Has the participant been judged to be in enough behavioral control to be safe in a PRP program and benefit from the rehab provided?** ❑ No ❑ Yes
5. **Will the participant's level of cognitive impairment, current mental status or developmental level negatively impact their ability to benefit from PRP?** ❑ No ❑ Yes
6. **Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting?** ❑ No ❑ Yes

Note: PRP may not routinely be provided <u>in conjunction with:</u> Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT), Targeted Case Management (TCM), Inpatient Psychiatric Services, Crisis Residential Services, Psychiatric Residential Treatment Facility (PRTF)/ Residential Treatment Center (RTC), Mental Health- Intensive Outpatient Program (IOP), Mental Health- Partial Hospitalization Program (PHP), Respite, Therapeutic Behavioral Services (TBS), Residential Substance Use Disorder Treatment Level 3.3 or higher, Substance Use Disorder-Intensive Outpatient Program (IOP), Substance Use Disorder- Partial Hospitalization Program (PHP).

Functional Impairments- Individuals ***MUST*** experience *at least 1* of the below *within the last 3 months* and it must relate back to their primary mental health diagnosis.

**** The individual's emotional disturbance has resulted in:**

A clear, current threat to the youth's ability to be maintained in their customary setting.
<u>*Please provide examples:*</u>

An emerging risk to the safety of the youth or others.
<u>*Please provide examples:*</u>

Significant psychological or social impairments causing serious problems with peer relationships and/or family members.
Please provide examples:

What evidence exists to show that the current intensity of outpatient treatment for this individual has been insufficient?

How will PRP serve to help this youth get to age appropriate development, more independent functioning and independent living skills?

Is a documented crisis response plan in progress or completed? ❑ No ❑ Yes
Has an individual treatment plan/Individual rehabilitation plan been completed? ❑ No ❑ Yes

Comments: *Please address any additional needs and/or areas of concern.*

TIDEMARK BEHAVIORAL HEALTH
7822 Eastern Ave. Baltimore, MD 21224 I info@tidemarkinterventions.com I 1.800.847.6028

Referral Contact: *If LMSW or LGPC, please include your clinical supervisor's name, credentials, &Medicaid Affiliate NPI number further below. (LMSW's must be signed off by an LCSW-C & LGPC's must be signed off by an LCPC)*
What type of provider is making the referral? ❑ Inpatient ❑ Residential Crisis Mobile Community Treatment ❑ Incarceration ❑ Mental Health Residential Treatment Center ❑ Form of treating Outpatient Provider

Must have an LCPC, LCSW-C, Psychiatrist, or Psychologist complete the Clinical Supervisor fields below if you are an LMSW or LGPC

Clinician & Credentials/ Agency:			
Medicaid Affiliated NPI Number:			
Referral Contact #:		**Email:**	
Date:		**Signature:**	

Clinical Supervisor & Credentials:			
Medicaid Affiliated NPI Number:			
Supervisor Contact #:		**Email:**	
Date:		**Signature:**	

** **Please email to** ***info@tidemarkinterventions.com*** **or fax to** ***1 (800) 847-6028*** **