Key Point Health Services, Inc.
Child & Adolescent Psychiatric Rehabilitation Program (PRP)
REFERRAL FORM

IDENTIFYING INFORMATION:

Child's Name:		**Date of Birth:**		**Age:**	
Address:		**Social Security #:**		**Sex:**	□ Male □ Female
City, State, Zip:		**Medical Assistance #:**			
Phone #:		**Access to Transportation for On Site Activities:**			□ Yes □ No
Adult Contact's Name:		**Relationship:**	□ Parent □ Guardian □ Foster Care Provider		
Address *(If different):*		**Does Contact Person Have Legal Custody?**			□ Yes □ No
City, State, Zip:		**Phone Number:**			

DSM V DIAGNOSES*:* (A minor must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP.)

Behavioral Diagnoses: *(ICD-10 Diagnosis Code Required)*	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
Primary Medical Diagnoses: *(Required)*	Description:			
	Description:			
Social Elements Impacting Diagnoses: *(Required)*	□ None □ Educational □ Financial □ Access to Health Care □ Legal System/Crime □ Primary Support □ Housing □ Occupational □ Social Environment □ Homelessness □ *Other Psychosocial & Environmental □ Unknown *Explain "Other Psychosocial & Environmental elements:*			
Source of Diagnosis: *(Required)*		**Functional Assessment** *(If applicable)*	Measure Used:	Score:

REASON FOR REFERRAL: *(Indicate the areas you want the PRP to address.)*

☐ **Self Care Skills:** *(Check all that apply)*	☐ personal hygiene/grooming	☐ dressing self	☐ toileting
	☐ nutrition/dietary planning	☐ following routines (bed, school)	☐ self administration of meds
☐ **Semi-Independent Living Skills:** *(Check all that apply)*	☐ taking care of belongings	☐ maintaining living area	☐ safety skills
	☐ money management	☐ mobility skills	☐ accessing entitlements
☐ **Interactive Skills with Others:** *(Check all that apply)*	☐ interactive skills with peers	☐ interactive skills with family	☐ interactive skills with adults
☐ **Leisure/Social Skills:**	☐ community integration	☐ participation in activities	☐ developing natural supports
☐ **Anger Management Skills:**	*Add'l info (if needed):*		
☐ **Education:**	*Add'l info (if needed):*		
☐ **Symptom Management:**	*Add'l info (if needed):*		
☐ **Community/Family Resources:**	*Add'l info (if needed):*		
☐ **Other**	*Explain:*		

LICENSED MENTAL HEALTH PROFESSIONAL PROVIDING REFERAL:

Name & Credentials:		**Agency/Organization:**	
Street Address:		**Phone Number:**	
City, State, Zip:		**E-Mail Address:**	
Signature:		**Mental Health Treatment Currently Being Provided:**	□ Outpatient Mental Health Services □ Inpatient Mental Health Services □ Residential Treatment Center

- ***Attach a "Professional Assertion of Need for PRP Services" and a copy of the current Treatment Plan.***

PRP Staff: Date Referral, Assertion of Need & Tx Plan Received*:* _____ Screening Scheduled within 5 days?: ____ Yes _____ No
(If no, attach Attempts to Schedule Screening form w info)