Key Point
HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

Dear Fellow Professional,

Thank you for making a referral to Key Point Health Services Adult Psychiatric Rehabilitation Program (PRP).

Please Follow the Three Step Referral Process:

1. Confirm the client is interested in Psychiatric Rehabilitation Day Program Services.
2. Complete the one page Referral Form.
3. Forward the completed Form. Please use the fax number listed for the location best suited for the client.

Considerations for the Referral Process:

1. Clients that have Medical Assistance may start services within a week of receiving the returned referral information.

2. Clients that have **only SSDI and Medicare as their primary** are considered uninsured for PRP. Presently uninsured clients have no guarantee of authorization from Beacon Health and therefore may take longer to be approved for services.

A Licensed Mental Health Professional's signature is required on the referral form. In order to establish and maintain eligibility for Key Point Health Services, individuals should remain under the care of a psychiatrist and/or therapist while in the program.

Baltimore County Key Point PRP Locations

Key Point Health Services
Psychiatric Rehabilitation Program
1012 N. Point Road
Dundalk, MD 21224
Phone: 443-216-4770
Fax: 443-216-4771

Key Point Health Services
Psychiatric Rehabilitation Program
500 N. Rolling Road
Catonsville, MD 21228
Phone: 410-869-3504
Fax: 410-869-3508

Harford County Key Point PRP Location

135 N. Parke Street, Aberdeen MD 21001
Phone: 443-625-1560
Referrals may be faxed to **443-625-1540**

Individuals will be contacted and scheduled for an intake appointment. If additional information is needed, please contact us at the numbers listed.

Dundalk PRP
1012 North Point Road
Baltimore, MD 21222
Fax #: 443-216- 4771

Key Point Health Services
Psychiatric Rehabilitation Day Program
REFERRAL

Catonsville PRP
500 N. Rolling Road
Catonsville, MD 21228
Fax #: 410-869-3508

Harford PRP
135 N. Parke St.
Aberdeen, MD 21001
Fax#: 443-625-1540

Client Name: _____ MA#: _____DOB:_____ Race: _____
Address: _____Phone #_____
I am referring the patient for the following services: ☐ PRP Day Program
This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to the form.

Behavioral Diagnoses

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

Primary Medical Diagnoses:_____

Social Elements Impacting Diagnosis

☐ None ☐ Access to Health Care ☐ Housing Problems ☐ Social Environment
☐ Educational ☐ Legal System/Crime ☐ Occupational ☐ Homelessness
☐ Financial ☐ Primary Support ☐ Other Psychosocial/Enviro. ☐ Unknown

If client does not have Medical Assistance: SS#_____
The individual has a serious mental illness which required intervention of the Public Mental Health System in the last two years: Yes☐ No☐

Individual experiences at least three of the following:
☐Inability to maintain independent employment
☐Social behavior that results in interventions by the mental health system
☐Inability to procure financial assistance due to cognitive disorganization
☐Severe inability to establish or maintain social supports
☐Need or assistance with basic living skills

Current Medications (include dosage and frequency or attach current med sheet):_____
Is the individual med compliant: ☐yes ☐no

Presenting Symptoms: Please include hx of SI and HI: _____
_____

Criminal Hx- ☐yes ☐no

Reason for Referral:

1. Self-care skills- ☐personal hygiene, ☐grooming, ☐nutrition, ☐dietary planning, ☐food preparation, ☐self administration of medication.
2. Social Skills- ☐community integration activities, ☐developing natural supports, ☐developing linkages with and supporting the individual's participation in community activities.
3. Independent living skills- ☐skills necessary for housing stability, ☐community awareness, ☐mobility and transportation skills, ☐money management, ☐accessing available entitlements and resources, ☐supporting the individual to obtain and retain employment, ☐Health promotion and training, ☐individual wellness self management and recovery.

_____
Most Recent Psychiatric Hospitalization Date

_____ _____
Referring Mental Health Professional Signature and Credentials **Date**

_____ _____
Referring Professionals Name **Location and Phone Number**

_____ _____
Treating Psychiatrist Phone **Treating Therapist Phone**