Advanced Behavioral Health
Greater Maryland Youth

Phone: 301 345 1022 x7021
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Referral for Psychiatric Rehabilitation Program (PRP) Services

Referral Date:_____

Referral's Name and Number:_____

Source of Referral (circle one): *Therapist* *Psychiatrist* *Other:*_____

Patient Name:_____ **DOB**: _____

Ethnicity:_____ **Primary Language**:_____

Patient Address:_____

Guardian name and Telephone Number:_____

Patient Medical Assistance Number:_____

School:_____ **Grade:**_____

Where are outpatient services authorized: _____

Current medication regime:_____

What are the presenting problems? How long has it been a problem? Length of treatment:

_____

_____

_____

Describe consumer's strengths, skills and challenges: _____

_____

_____

Is the patient willing to learn the necessary skills to maintain in the community? Y or N

Significant family members/support:_____

Diagnosis:_____

Clinician's Signature and Credentials:_____

LOCATIONS (circle one):

Gaithersburg On/Off Site **Frederick On/Off Site**

Greenbelt On/Off Site **Baltimore On/Off Site**

For Psychiatric Rehabilitation Program use only:

*Date Referral Received:*_____

*Contacts with Patient or parent/legal guardian:*_____

*****Please Attach Current Psychiatric Assessment (must be within 6 months of referral date) *****