**PRP Referral form**

**Initial Referral**  **Concurrent Referral**

Thank you for referring this client to Nurturing Hope, LLC.

|  |  |  |
| --- | --- | --- |
| **CLIENT’S INFORMATION** | | **REFERRING PROVIDER/AGENCY INFORMATION** |
| Client’s Name: | | Provider/Agency Name: |
| Parent/ Guardian Name: | |
| DOB: | SSN: | Street Address: |
| Street Address: | | City, State, ZIP: |
| City, State, ZIP: | | Phone: |
| Home Phone: | Cell phone: | Fax: |
| Work Phone: | | Other Information: |
| Insurance Provider: | |
| Medicaid/Insurance #: | |

**Please answer these questions:**

**1. Reasons for Referral – Please include diagnosis (Please describe**)**.**

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| --- | --- | --- | --- | --- | --- | --- |
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|  | | | | | | |
| Frequency of Problem: |  | | | | | |
|  |  | | | | | |
| Severity of Problem |  | Mild |  | Moderate |  | Severe (been to ER or out of school) |

**Physician's Name**: Physician's Phone Number:

**2. Medications: Yes  No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Dosage | Frequency | Medication | Dosage | Frequency |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**3. Relevant past psychiatric/medical history/Previous Diagnosis**

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**4. Rehabilitation Activities**:

|  |  |
| --- | --- |
| Age appropriate self-care skills | Interactive skills with peers and authority figures |
| Social skills | Maintaining personal living space |
| Independent living skills | Maintaining age appropriate boundaries |
| Activities to support cultural interests | Maintaining personal safety in a social environment |
| Conflict resolution | Time management, including constructive use of structure and unstructured time |
| Anger management | Other: |

Referring Provider/Agency Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mail or fax this form, copy of the most recent medical record and psychosocial assessment/intake to our office 410-372-3936.

**NH STAFF ONLY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date Received: | | |  | | |
| Facility: | | |  | | |
| Staff Name | | |  | | |
|  | Referral Accepted Date of Appointment | |  | | |
|  | Referral Denied Reason: | |  | | |
| Referral status communicated to | |  | | **on** |  |