10 W Eager Street Ste. 200 Baltimore MD 21201

PRP REFERRAL FORM

Thank you for referring this client to Tender Hearts LLC. Please provide the following information and pertinent medical records so that we can provide the best and timeliest service.

Date: _____

Client Name:	**Gender:** ☐Male ☐Female
DOB:	**Social Security#:**
Address (*include city, state and zip*):	**Medical Assistance #:**
	Phone Contact: Cell: Home: Work:

Referral Source Information

Agency Name:	**Phone:**
Referring/Treating Clinician:	**Fax:**
Address (*include city, state and zip*):	

Employer/School

School/Employer Name:	**Phone:**
Grade (*if applicable*):	

Reason for Referral/ Presenting Problems

Please provide a detailed description of client behaviors and all treatment presentations *(include school concerns)*:

Please provide details regarding behavioral history (*include hospitalizations, out of home placement, previous mental health treatment etc.***):**

☐Check box if no previous hospitalizations or treatment history

Frequency of treatment provided to this individual:

☐At least 1x/week ☐At least 1x/month ☐At least 1x/6 months

How long has the individual been engaged in active outpatient treatment?

☐ Less than one month ☐2-3 months ☐4-6 months ☐7-12 months ☐More than 12 months

ADULT CLIENTS ONLY: Has the individual received PRP services from at least one other PRP agency within the past year?

☐Yes ☐No

Rehabilitation Services Needed:

☐Activities of Daily Living
☐Anger/Temper/Conflict Resolution
☐Assertiveness/Self-esteem
☐Community Activity
☐Family/Natural Supports
☐Safety to Self/Others
☐School Performance
☐Sexual Issues
☐Social Skills/Peer Interaction
☐Substance Abuse Issues
☐Vocational Skills
☐Leisure Skills
☐Work/Job Performance
☐Legal Issues
☐Money Management

10 W Eager Street Ste. 200 Baltimore MD 21201

☐Finances	☐Coping Skills	☐Dietary/Food Preparation
☐Home/Housing	☐Conflict Resolution	☐Crisis Management Skills
☐Self-Care Skills	☐Trauma	☐Physical Health
☐Self-Injurious Behaviors	☐Medication Compliance Skills	

Current Treatment(s) Goals *(Please include current treatment goals, type of services received)*:

Goals:

Diagnosis: If applicable, please indicate current DSM V diagnoses:

Primary Behavioral Diagnosis:	
Diagnosis Code 1:	**Description:**
Additional Behavioral Diagnosis:	
Diagnosis Code 2:	**Description:**
Diagnosis Code 3:	**Description:**
Primary Medical Diagnosis: (please include all medical concerns)	
Diagnosis Code:	**Description:**

Socioeconomic/Psychosocial Assessment:

☐None ☐Limited Primary Support ☐Housing Problems ☐Social Environment Concerns

☐Financial Problems ☐Access to Healthcare ☐Educational Problems ☐Legal ☐Unknown

Diagnosed/Referred By: (*Please include licensure***)**

Medications:

Type of Medication	Dosage:	Frequency:

Custodial Care:

Name of Guardian:	Phone:
Address:	
Foster Care Placement/DSS (*if applicable*):	

Collaboration Agreement

I, _____(Therapist Name and Title), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

*** Please send or fax this form to our office along with relevant medical records (*Clinic/hospital notes, test, lab or other imaging results, and pertinent consultations. Please include any necessary insurance referral authorizations. **Thank you.)***

Signatures

Referring Provider/Agency Staff Signature: _____

Position/Title: _____ Date: _____

Clinical Director/Co-Signer (LCSW-C, LCPC, PhD) Signature & Date: _____

10 W Eager Street Ste. 200 Baltimore MD 21201

TENDER HEARTS USE ONLY

Date Received: _____

Facility: _____

_____ Referral Accepted _____ Date of Appointment

_____ Referral Denied _____ Reason

Referral status communicated to _____ Date _____

Insurance Authorization Number_____

Number of Authorization Visits _____

Dates of Authorization from: _____ To: _____

Scheduled Diagnostic Interview ____ Yes ____ No Date: _____ Therapist: _____

Date Assigned: _____ Counselor: _____

Comments:

_____

_____