INTEGRATED BEHAVIORAL HEALTH, LLC

4200 Forbes Blvd. Suite 110, Lanham, MD 20706
Phone: (301) 499-4240 • Fax: (240) 455-6847
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REFERRAL FORM

Attention: This form must be filled out in its entirety to allow for medical necessity and authorization for services. This form may be faxed to the number listed above

Client Name: DOB: _____ **Race:** _____

Address: _____ **Phone:** _____

Insurance information: ☐ **Medicaid ID** _____ **Medicare** ☐ **ID#** _____
☐ **Private Insurance (list payer):** _____ **Member ID#** _____
Payer Phone #: _____ **If client does not have Medical Assistance, list SSN:** _____

The following services are requested:

☐ PRP –A (Psychiatric Rehab. Program-Adults)
☐ OMHC (Mental Health Clinic)
☐ OTHER (e.g. Primary Care Services)
☐ PDTP (Day Prog.)
☐ IOP-SUD
☐ PHP (Partial Hosp. Prog)
☐ IOP-MH

_____

This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years: ☐ Yes ☐ No
If yes, please specify dates: _____ **Hospital Name:** _____

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
☐ 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
☐ 296.89/F31.81 Bipolar II Disorder
☐ 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, w/o Psychosis
☐ 296.40/F31.9 Bipolar I, Most Recent Hypomanic, Unspecified
☐ 301.83/F60.3 Borderline Personality Disorder
☐ _____
☐ _____

Primary Medical Diagnoses:

_____

Social Elements Impacting Diagnosis

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

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Individual experiences at least three of the following for PRP and at least two for Day Treatment/PHP:

☐ 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 support.
☐ Need or assistance with basic living skills.

List of Current Medicines, Dose, and Frequency: (You may attach a copy of list of medicines)

Medication Name	Dose	Frequency

Is the individual med compliant? ☐ Yes ☐ No

Allergies: This person requires a prescription for Epi-Pen for specific allergies. ☐ Yes ☐ No

Presenting Symptoms: Please include history of SI and HI

_____

_____

Criminal History ☐ 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 ☐ health promotion and training
   ☐ accessing available entitlements & resources ☐ supporting the individual to obtain & retain employment ☐ individual wellness self-management and recovery

Comments: _____

_____

Referring Mental Health Professional's Credentials & Information

Name & Credentials: _____

Referring Professional's Signatures: _____ **Date:** _____

Office Location: _____

Treating Psychiatrist or Therapist: _____ **Phone:** _____