



# BACHS Healthcare P.R.P. Referral Form

Baltimore Area Community Health Services LLC  
4128 Hayward Avenue, Baltimore, MD 21215

**410-241-6317 | Fax 410-697-6055 | Info@BachsHealthcare.com**

Name \_\_\_\_\_ Date \_\_\_\_\_ Sex: M / F / O Race: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

MA# \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Marital Status S / M / D Education: \_\_\_\_\_ Veteran?: Y/N Recent Arrest?: Y/N

Minor Parent/Guardian Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PRP eligibility is restricted to the following **ICD-10 diagnoses for Adults (Minors can have any diagnosis)**. Please check all qualifying diagnoses:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> F20.9: Schizophrenia<br><input type="checkbox"/> F20.81: Schizophreniform Disorder<br><input type="checkbox"/> F25.0: Schizoaffective Disorder, Bipolar Type<br><input type="checkbox"/> F25.1: Schizoaffective Disorder, Depressive Type<br><input type="checkbox"/> F28: Other Specified Schizophrenia Spectrum and Other Psychotic Disorder<br><input type="checkbox"/> F29: Unspecified Schizophrenia Spectrum and Other Psychotic Disorder<br><input type="checkbox"/> F22: Delusional Disorder<br><input type="checkbox"/> F33.2: Major Depressive Disorder, Recurrent Episode, Severe<br><input type="checkbox"/> F33.3: Major Depressive Disorder, Recurrent Episode, With Psychotic Features | <input type="checkbox"/> F31.13: Bipolar I Disorder, Current or Most Recent Episode Manic, Severe<br><input type="checkbox"/> F31.2: Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features<br><input type="checkbox"/> F31.4: Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe<br><input type="checkbox"/> F31.5: Bipolar I Disorder, Current or Most Recent Episode Depressed, With Psychotic Features<br><input type="checkbox"/> F31.0: Bipolar I Disorder, Current or Most Recent Episode Hypomanic<br><input type="checkbox"/> F31.9: Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified | <input type="checkbox"/> F31.9: Bipolar I Disorder, Current or Most recent episode, Unspecified<br><input type="checkbox"/> F31.9: Unspecified Bipolar and Related Disorder<br><input type="checkbox"/> F31.81: Bipolar II Disorder<br><input type="checkbox"/> F21: Schizotypal Personality Disorder<br><input type="checkbox"/> F60.3: Borderline Personality Disorder<br><input type="checkbox"/> Other (for Minors only):<br><br><hr/> <hr/> |
|--|--|--|

### Reason for PRP Referral (Clinical, please identify specifics):

**Self-Care/ Social Skills:** Grooming ( ) Personal Hygiene ( ) Nutrition ( ) Food Preparation ( ) Medication ( ) Physical Health ( ) Exercise ( ) Recovery ( ) Wellness ( ) Communication ( ) Peer Support ( ) Family ( ) Community Resources ( ) Activities & Leisure ( ) Other: \_\_\_\_\_

**Independent Living Skills:** Home Maintenance ( ) Finances ( ) Transportation ( ) Entitlement ( ) Community ( ) Awareness & Safety ( ) Employment ( ) Adult Education ( ) Shopping ( ) Other: \_\_\_\_\_

**Signs & Symptoms:** Mood Swings ( ) Crying Fits ( ) Anger Outbursts ( ) Hallucinations ( ) Fight or Flight ( ) Self Isolation ( ) Grieving ( ) Personality Shift ( ) Focus Problems ( ) Concentration Issues ( ) Other: \_\_\_\_\_

### Client Goals (Short-Term & Long-Term):

Therapist Signature: \_\_\_\_\_ Printed Name & Credentials: \_\_\_\_\_

Agency Name & Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_