BACHS Healthcare PRP Referral Form

Psychiatric Rehabilitation Program

Baltimore Area Community Health Services LLC
4128 Hayward Ave #G, 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 _____________________ Education:_________________ Veteran?: Y/N Recent Arrest?: Y/N

Minor Parent/Guardian Name ____

Emergency Contact ______________________ Relationship __________________Phone # _______________________

Address: ____City ___________________ State ____ Zip __________

DSS/DJJ Involvement (Yes / No) DSS/DJJ Worker's Name ________________________ Phone # _______________

PRP eligibility is restricted to the following **DSM V/ICD-10 diagnoses for adults (Minor can have any diagnosis)**: 295.40/F20.81, 295.90/F20.9, 295.70/F25.1, 298.8/F28, 298.9/F29, 297.1/F22, 296.33/F33.2, 296.34/F33.3, 296.43/F31.13, 296.44/F31.2, 296.53/F31.4, 296.54/F31.5, 296.40/F31.0, 296.40/F31.9, 296.7/F31.9, 296.80/F31.9, 296.89/F31.81, 301.22/F21, 301.83/F60.3

Referral Diagnosis	**Diagnosis Code**	
______________________________________	___________________________________	**(Axis I)**
______________________________________	___________________________________	

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

Self-Care Skills: Grooming ( ) Personal Hygiene ( ) Nutrition ( ) Food Preparation ( ) Medication ( ) Physical Health ( ) Exercise ( ) Recovery ( ) Wellness ( ) Other:____

Social Skills: 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:___________________________

Short Term Goals ____

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Long Term Goals: ____

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Therapist Signature: ____________________ Therapist Printed Name & Credentials____________________________

Referring Agency Name Address: ________________________________City _____________ State ____ Zip ________

Phone Number:_____________________________ e-mail: ____