BACHS Healthcare P.R.P. Referral Form

Baltimore Area Community Health Services LLC
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Name _____ Date _____ Sex Ⓜ/Ⓕ/Ⓞ Gender _____ Pronouns _____

Address _____ City _____ State _____ ZIP _____

Phone # _____ DOB _____ SS# _____ Race _____ Ins Co _____

MA# _____ Relationship Status Ⓢ/Ⓜ/Ⓓ/Ⓟ/Ⓦ Education _____ Veteran? Ⓨ/Ⓝ

Recent Arrest? Ⓨ/Ⓝ 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:

- ❑ **F20.9: Schizophrenia***
- ❑ **F20.81: Schizophreniform Disorder**
- ❑ **F25.0: Schizoaffective Disorder, Bipolar Type**
- ❑ **F25.1: Schizoaffective Disorder, Depressive Type**
- ❑ **F28:Other Specified Schizophrenia Spectrum and Other Psychotic Disorder***
- ❑ **F29:Unspecified Schizophrenia Spectrum and Other Psychotic Disorder***
- ❑ **F22:Delusional Disorder**
- ❑ **F33.2:Major Depressive Disorder, Recurrent Episode, Severe**
- ❑ **F33.3:Major Depressive Disorder, Recurrent Episode, With Psychotic Features ***
- ❑ **F31.13:Bipolar I Disorder, Current or Most Recent Episode Manic, Severe**
- ❑ **F31.2:Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features ***
- ❑ **F31.4:Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe**
- ❑ **F31.5:Bipolar I Disorder, Current or Most Recent Episode Depressed, With Psychotic Features ***
- ❑ **F31.0:Bipolar I Disorder, Current or Most Recent Episode Hypomanic**
- ❑ **F31.9:Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified**
- ❑ **F31.9:Bipolar I Disorder, Current or Most Recent episode, Unspecified**
- ❑ **F31.9: Unspecified Bipolar and Related Disorder**
- ❑ **F31.81: Bipolar II Disorder**
- ❑ **F21:Schizotypal Personality Disorder**
- ❑ **F60.3: Borderline Personality Disorder**

If psychosis noted as DX *
◯ Auditory ◯ Visual

❑ **Other (for Minors only):**

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

(Providers must select a minimum of 3 out of the 7 questions below):

When answering, please follow the sentence structure of 'What is the [Diagnosis], what symptoms affect the client based on the DX and how do those symptoms hinder the client in that area (question)'

1. Does the client struggle with obtaining/maintaining employment? Please indicate due to which of the following causes:
◯ Depressive symptoms, ◯ Mood swings , ◯ Organizational deficits, ◯ Lack of social support , ◯ Difficulty with hygiene/self care, ◯ Hallucinations/delusions

Please describe:
e.g. Client suffers from mood swings which causes conflict within the workplace.

2. Does the participant have marked inability to perform instrumental activities of daily living?
◯ Shopping , ◯ Meal preparation, ◯ Laundry, ◯ Basic housekeeping, ◯ Medication management, ◯ Transportation, ◯ Money management

Please describe:
e.g. Client has trouble completing basic tasks such as laundry, housekeeping, meal preparation as they lack motivation and often avoids completing tasks.

3. Does the participant have marked inability to establish/maintain a personal support system?
◯Yes ◯No

If yes, please describe:
e.g. Client suffers from mood swings which in turn often cause conflict with personal support system by pushing them away.

4. Does participant have deficiencies of concentration/ persistence/pace leading to failure to complete tasks?
◯Yes ◯No

If yes, please describe:
e.g. Client has trouble completing tasks as they often deal with anger outbursts and get frustrated easily which often leads to them failing to complete tasks.

5. Is the participant unable to perform self-care:
◯Hygiene, ◯ Grooming, ◯Nutrition, ◯ Medical care, ◯Safety

If yes, please describe:
e.g. Client has trouble completing basic hygiene as they often feel unmotivated to complete dental hygiene, showering, changing of clothes.

6. Does the participant have marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities?
◯Yes ◯No

If yes, please describe:

7. Does the participant have marked inability to procure financial assistance to support community living?
◯Yes ◯No

If yes, please describe:
e.g. Client has trouble accessing financial support as they often have trouble understanding forms and rules related to the assistance requested. This in turn causes anger outbursts and limits access to resources for the client.

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

Therapist Signature: _____ Printed Name & Credentials: _____

Agency Name & Address: _____ City _____ State _____ Zip _____

Phone Number: _____ E-mail: _____