THE Southern Maryland Community NETWORK

Champions of Behavioral Health

Applicant Name

www.smcni.org

Please send referral via secured email to intake@smcni.org or facsimile to the fax number below.

Referral Application for Adult Services

PLEASE FAX BOTH PAGES TO THE OFFICE SERVING THE INDIVIDUAL'S COUNTY OF RESIDENCE

CALVERT COUNTY
305 Prince Frederick Blvd.
Prince Frederick, MD 20678
(410) 535-4787 Office
(410) 535-4965 Fax

ST. MARY'S COUNTY
41900 Fenwick Street, Suite 5
Leonardtown, MD 20659
(301) 475-9315 Office
(301) 475-9317 Fax

CHARLES COUNTY
2670 Crain Highway, Suite 505
Waldorf, MD 20601
(301) 932-9146 Office
(301) 932-9361 Fax

For **PRP ELIGIBILITY ADULTS** MUST HAVE ONE OF THE FOLLOWING DIAGNOSES. If this is a PRP Referral please check the correct diagnosis. Also send with this referral verification of diagnosis signed by a Licensed Mental Health Practitioner. The diagnosis should also be indicated on the second page following the DSM V Diagnosis Code prompt.

- ☐ 295.90/F20.9 Schizophrenia
- ☐ 295.40/F20.81 Schizophreniform Disorder
- ☐ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ 295.70/F25.1 Schizoaffective Disorder, Depressive Type
- ☐ 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- ☐ 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- ☐ 297.1/F22 Delusional Disorder
- ☐ 296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- ☐ 296.34/F33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features
- ☐ 301.22/F21 Schizotypal Personality Disorder
- ☐ 296.43/F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
- ☐ 296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic Psychotic Features
- ☐ 296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
- ☐ 296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
- ☐ 296.40/F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
- ☐ 296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
- ☐ 296.7/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
- ☐ 296.80/F31.9 Unspecified Bipolar and Related Disorder
- ☐ 296.89/F31.81 Bipolar II Disorder
- ☐ 301.83/F60.3 Borderline Personality Disorder

Psychiatric Rehabilitation or Case Management Services Needed:

- ☐ Activities of Daily Living
- ☐ Anger/Temper/Conflict Resolution
- ☐ Assertiveness/Self-esteem
- ☐ Community Activity
- ☐ Family/Natural Supports
- ☐ Finances
- ☐ Home/Housing
- ☐ Social Skills
- ☐ Dietary/Food Preparation
- ☐ Crisis Management Skills
- ☐ Physical Health
- ☐ Substance Abuse Issues
- ☐ Coping Skills
- ☐ Benefits/Social Services
- ☐ Vocational Assistance
- ☐ Leisure Skills
- ☐ Money Management
- ☐ Medication Compliance Skills
- ☐ Self Care Skills
- ☐ _____
- ☐ _____

History of Problems, i.e. hospitalizations, risk-taking behaviors, suicidal/homicidal ideations/behaviors, etc.:

_____

_____

_____

_____

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A recent Psychiatric Evaluation should accompany this referral before it can be processed, documenting the current DSM-5, ICD-10 codes within our priority population.

Date of Application:_____

Name: _____ Age:_____ Date of Birth:_____ Sex: ☐M ☐F

Social Security#:_____ DSM V diagnosis code:_____ GAF:_____

Address:_____ County of Residence:_____

City/State/Zip:_____ Phone:_____

Psychiatrist:_____ Phone:_____

Address:_____ City/State/Zip:_____

Therapist:_____ Phone:_____

Address:_____ City/State/Zip:_____

REFERRAL SOURCE:

Name:_____ Title:_____

Organization:_____ Phone:_____

Address:_____ City/State/Zip:_____

FINANCIAL STATUS

Medical Assistance M.A.#_____ Medicare M.C. #_____

Other Insurance Policy#_____

SSI☐ SSDI☐ Earned Income☐ Source:_____

Other Benefits _____

I hereby request the following services:

☐Psychiatric Rehabilitation Services ☐Targeted Case Management Services

_____ _____

Applicant's Signature Date

If requesting PRP services and the Referral Source/ Therapist is an LM/LG then please provide the name and credentials of the clinical supervisor:

_____

Name Credentials

Referral Source/Staff Member, please check one:

☐ Verbal consent obtained during tele-health visit.

☐ Verbal consent obtained during face to face visit.

_____ _____

Printed Name Signature

Date:_____

Psychiatrist or Therapist

☐ I do feel this person is appropriate for Psychiatric Rehabilitation Services.

☐ I do not feel this person is appropriate for Psychiatric Rehabilitation Services.

_____

Signature