Children's Choice PRP/Respite Referral Form

Referred by: _____Phone: _____

Please Check One of the Following:

◯ Parent ◯ Therapist ◯ Psychiatrist ◯ Other:_____

Referral Type: ◯ PRP ◯ Respite

Client Information: 1915i Approved: ◯ Yes ◯ No

Name: _____ Phone: _____

Address: _____ SS#: _____

_____ DOB: _____

Gender: ◯ M ◯ F Race: ◯ W ◯ B ◯ H ◯ O Age: _____

Insurance: _____ Insurance #: _____

Caretaker: _____ Relationship: _____

Household Members:

Behavioral Diagnoses & Code: (attach a copy of ITP/IRP)

Diagnostic Category 1: _____

Diagnostic Category 2: _____

Diagnostic Category 3: _____

Diagnostic Category 4: _____

Diagnostic Category 5: _____

Primary Medical Diagnosis:

Diagnostic Category 1: _____

Diagnostic Category 2: _____

Diagnostic Category 3: _____

Social Elements Impacting Diagnosis:

☐ None	☐ Problems with access to Health Care services	☐ Housing problems	☐ Problems related to the social environment
☐ Educational Problems	☐ Problems related to interaction w/legal system/crime	☐ Occupational problems	☐ Homelessness
☐ Financial Problems	☐ Problems with primary support group	☐ Other psychosocial and environmental problems	☐ Unknown

Current Need for PRP: (Precipitating Events)

Mental Health TX Provider:

Agency: _____ Therapist: _____

Address: _____ Phone: _____

Medication (List): Compliant? ◯ Y ◯ N

Current Treatment: (modality and frequency)

Treatment HX: (hospitalizations / other agencies / etc)

Fire-setting: ◯ Y ◯ N

Explain:

Sexual Acting Out: ◯ Y ◯ N

Explain:

Substance Abuse: ◯ Y ◯ N

Explain:

Suicidal / Homicidal Ideation: ◯ Y ◯ N

Explain:

School Problems: (HX):

Family HX: (Mental Health/AOD Abuse/TX)

Other Pertinent Information:

Signature: _____