ALLOVER HEALTHCARE OUTPATIENT MENTAL HEALTH CLINIC REFERRAL FORM

Referral Source Information

Agency/Individual Name:_____ Phone #: _____

Address:_____ Fax #: _____

EMAIL ADDRESS:_____

Referring Individual Credentials:_____ Referring Individual Signature: _____

Location: 5450 Reisterstown Road STE 304 Baltimore, MD 21215 Phone: 443-759-8827 Fax: 443-759-8870
Email: info@alloverhealthcaregroup.com Website: www.alloverhealthcaregroup.com

DATE OF REFERRAL: _____

Client Information

Client Name:_____ Date of Birth:_____ Gender: ○Male ○Female

Parent/ Legal Guardian Name: _____ Foster Parent: ○Yes ○No (if yes submit court order copy)

Age:_____ **MA #:**_____ **MCO:**_____ **Social Security #:**_____

Ethnicity:_____ Is there a current or previous substance use? ○Yes ○No If yes, currently in treatment? ○Yes ○No

Home Address:_____ Is the client Homeless? ○Yes ○No

Best Number to Contact:_____ **email address**: _____

Services Requested

☐ Mental Health Evaluation/Assessment	☐ Psychiatric Rehabilitation Services/ PRP
☐ Individual Therapy	☐ Substance Abuse Services: (circle one) Counseling, DUI/DWI Groups
☐ Group Therapy	☐ Adult Targeted Case Management
☐ Family Therapy	☐ Psychiatric Services/ Medication Evaluation
☐ Community Supported Employment Services	☐ Residential Services - Community Housing MH/SUD

Reason for Referral/Presenting Problems (PLEASE BE SPECIFIC)

_____

_____

_____

Is the client currently on psychotropic medications? ○ yes ○ no
If yes, please list all medications_____

- Has the client recently been discharged from an outpatient Mental Health Facility/ Hospital: ○Yes ○No
  If yes, have they provided a copy of the aftercare plan?): ○Yes ○No
- Has the client been arrested in the past six months? ○Yes ○No If Yes, How many times? _____
- Is the client a veteran? ○Yes ○No
- Currently enrolled in educational program? ○Yes ○No **Highest Grade Completed** _____
  School Name: _____
- Currently Employed? ○Yes ○No

Office Use Only

Insurance Authorization Number_____ Number of Auth. Visits:_____
Dates of Authorization From:_____ To: _____
Scheduled Diagnostic Interview ○Yes ○No Date:_____ Therapist:_____
Immunization Record Request ○Yes ○No Date: _____
Date Assigned/Comments:_____

Allover Healthcare Group™
Healthcare | Technology | Education Solutions

ALLOVER HEALTHCARE OUTPATIENT MENTAL HEALTH CLINIC REFERRAL FORM

COMPLETE FOR PRP SERVICES REQUESTS ONLY:

Diagnosis: please indicate current DSM diagnoses. **(MUST HAVE AXIS I DIAGNOSIS)**
ADULTS **MUST HAVE ONE OF THE FOLLOWING DIAGOSIS FOR PRP ELIGIBILITY**

☐ F20.9 Schizophrenia	☐ F31.13 Bipolar I, Most Recent Manic, Severe
☐ F20.81 Schizophreniform Disorder	☐ F31.4 Bipolar I, Most Recent Depressed, Severe
☐ F25.1 Schizoaffective Disorder, Depressive	☐ F31.0 Bipolar I, Most Recent Hypomanic
☐ F29 Unspecified Schizophrenia Spectrum & other Psychotic Disorder	☐ F31.9 Bipolar I Disorder, Unspecified
☐ F25.0 Schizoaffective Disorder, Bipolar Type	☐ F31.2 Bipolar !, Most Recent Manic, with Psychosis
☐ F28 Other specified Schizophrenia Spectrum and other Pychotic Disorder	☐ F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis
☐ 297.1/ F22 Delusional Disorder	☐ F31.9 Bipolar I, Most Recent Hypomic, Unspecified
☐ F33.2 MDD, Recurrent Episode, Severe	☐ F31.81 Bipolar II Disorder
☐ F33.3 MDD, Recurrent, With Psychotic Features	☐ F60.3 Borderline Personality Disorder
	☐ F21 Schizotypal Personality Disorder
	☐ F31.9 Unspecified Bipolar Disorder

PLEASE USE ICD-10 CODE

Axis I: ICD CODE:

Diagnosis given by:

PLEASE COMPLETE FOR PRP AND TARGETED CASE MANAGEMENT REQUESTS

Rehabilitation Services Needed:

☐ Activities of Daily Living ☐ Safety to Self/Others ☐ Vocational Skills
☐ Anger/Temper/Conflict Resolution ☐ School Performance ☐ Leisure Skills
☐ Assertiveness/Self-esteem ☐ Sexual Issues ☐ Work/Job Performance
☐ Community Activity ☐ Social Skills/Peer Interaction ☐ Legal Issues (# of arrests?)
☐ Family/Natural Supports ☐ Substance Abuse Issues ☐ Money Management
☐ Finances ☐ Coping Skills ☐ Dietary/Food Preparation
☐ Home/Housing ☐ Trauma ☐ Crisis Management Skills
☐ Self-Care Skills ☐ Medication Compliance Skills ☐ Physical Health

History of Challenges and Rehabilitation Needs:

_____
_____
_____
_____

In Current Treatment?

1. **Therapist Name and Phone Number:** _____
2. **Psychiatrist Name and Phone Number:** _____

Office Use Only

Insurance Authorization Number_____Number of Auth. Visits:_____
Dates of Authorization From:_____To: _____
Scheduled Diagnostic Interview ○Yes ○No Date:_____Therapist:_____
Immunization Record Request ○Yes ○No Date: _____
Date Assigned/Comments:_____