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@allovehealthcaregroup.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)

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____

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 TM
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:____________________