CONTINUOUS GROWTH

PSYCHIATRIC REHABILITATION PROGRAM

Completed referral forms should be faxed to (240) 341-3505 or emailed to info@continuousgrowth.org. For more information, please contact the main office at 410-600-3349

REFERRAL SOURCE INFORMATION

Date of Referral: _____ Referring Agency _____

Worker (title and credentials): _____ Phone_____

Fax Number: _____ Email Address: _____

CLIENT INFORMATION

Consumer Name: _____ Gender: _____ Marital Status: _____

SSN: _____ DOB: _____ AGE: _____ RACE: _____

Medical Assistance #: _____ Legal Guardian: _____

Full Address: _____

Phone: _____ Alternate Phone: _____

Primary Care Physician: _____ Phone Number: _____

Employer/School: _____ Grade: _____

Address: _____ Phone:_____

Rehabilitation Services Needed:

- ❑ Coping Skills
- ❑ Social Skills/Peer Interaction
- ❑ Other:
- ❑ Assertiveness/Self-esteem
- ❑ Behavior Interventions
- ❑ Other:
- ❑ Adult Vocational/Educational Skills
- ❑ School Performance
- ❑ Other

Current Treatment: Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participates.

1. _____

2. _____

Diagnosis: please indicate current DSM V diagnoses.

ICD 10 Code: _____ DSM V Code: _____

ICD 10 Code: _____ DSM V Code: _____

Diagnosis given by: _____ Date: _____

Medications (Please provide name and dosage amount)

Please forward the most recent assessment and/or treatment plan when sending this referral.

Printed Name and Credentials: _____

Date: _____ **Signature:** _____

Date Received: Approve/Denied	Coordinator Assigned Assignment Date:	Authorization Dates: