

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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Coping Skills | <input type="checkbox"/> Assertiveness/Self-esteem | <input type="checkbox"/> Adult Vocational/Educational Skills |
| <input type="checkbox"/> Social Skills/Peer Interaction | <input type="checkbox"/> Behavior Interventions | <input type="checkbox"/> School Performance |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other |

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

- _____
- _____

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:
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