MADONNA
HEALTHCARE SERVICES, INC.

2300 Garrison Blvd, (Suite 230) Baltimore, MD 21216
Phone: (410) 233-4039 Fax: (410) 233-4052

REFERRAL FOR SERVICE

DISCLAIMER: Active Medical Assistance Insurance is required for PRP Referral and Services. Also, a signature, credentials, and NPI number are required from the licensed clinician who is referring this Consumer. (PLEASE PRINT, SIGN, and DATE)

Please indicate one of the following: ________On-site/Off-site ________(Off-site Only)

CONSUMER'S IDENTIFICATION INFORMATION

Name: ____ D.O.B. ______/_______/___________ Race: ______________________

Social Security Number:______________________________ Gender: ________________ Marital Status: ___________________

Address (including city & state): ____

Home Phone: ______________________ Cell Phone: _______________________ Email (optional): ________________________

Insurance: ____ Policy #:_______________________________________

Allergies/Health Concerns: ____

Highest Level of Education attained: ____

Does the Consumer have any children?: ☐Yes ☐No If YES, how many?_________ Is the consumer a veteran? ☐Yes ☐No

If YES, are they a veteran of : ☐IRAQ ☐AFGHANISTAN ☐OTHER: ______________________________

When was this Veteran's most recent deployment? ____

REASON FOR REFERRAL

Current symptoms/mental health status and functional impairments: ____

____

____

Has this Consumer demonstrated marked functional impairments for at least 2 years? ☐Yes ☐No

Has this Consumer received PRP services from at least one other PRP within the past year? ☐Yes ☐No

What is the consumer expected to gain from PRP services? ____

____

____

Check all that apply:

____ Need help with ADL's
____ Needs help with therapy compliance
____ Tends to isolate self
____ Needs help with coping skills
____Needs help with medication compliance
____ Has poor/severely impaired skills
____ Needs help with relapse prevention skills
____ Needs help maintaining stable housing

DIAGNOSIS

Behavioral Diagnosis (#1) :____

Behavioral Diagnosis (#2) :____

Behavioral Diagnosis (#3) :____

Primary Medical Diagnosis :____

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CURRENT MEDICATIONS

NAME OF MEDICATION:	DOSAGE:	(PLEASE CIRCLE PURPOSE FOR MEDICATION)
______________________	________	SOMATIC / PSYCHIATRIC
______________________	________	SOMATIC / PSYCHIATRIC
______________________	________	SOMATIC / PSYCHIATRIC

INPATIENT/OUTPATIENT PSYCHIATRIC TREATMENT HISTORY

Has Consumer ever been admitted for inpatient psychiatric treatment? ☐Yes ☐No If YES, please indicate the approximate number of inpatient psychiatric admissions during lifetime: _______________

Please complete the following for the most recent hospitalizations:

Hospital: ________________________________ Admission Date: ___/___/_____ Discharge Date: ___/___/_____
Hospital: ________________________________ Admission Date: ___/___/_____ Discharge Date: ___/___/_____

DRUG/ALCOHOL HISTORY:

Alcohol?: ☐Yes ☐No If YES, please indicate date of most recent use: ______________________________

Other Drugs?: ☐Yes ☐No If YES, List substance(s) and Date(s) of most recent use: ______________________________

____

LEGAL HISTORY

Any current legal issues/concerns?: ☐Yes ☐No ☐UNKNOWN If YES, please explain: ___________________________

____

Previous/Past legal issues?: ____

____

Discuss any history of impulsive, explosive, violent or homicidal behaviors: ______________________________

____

FAMILY HISTORY OF MENTAL ILLNESS & HISTORY OF TRAUMA:

Mental Illness: ____

Trauma: ____

PROVIDER INFORMATION

Treating Psychiatrist: ______________________________ Organization: ______________________________

Address: ____ Phone Number:____________________

Mental Health Therapist: ______________________________ Organization: ______________________________

Address: ____ Phone Number:____________________

Primary Care Physician: ______________________________ Organization: ______________________________

Address: ____ Phone Number:____________________

REFERRING CLINICIAN NPI NUMBER: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Referred by: ______________________________ ______________________________ ____________

PLEASE PRINT NAME & CREDENTIALS — PROVIDE SIGNATURE & CREDENTIALS — **DATE**

Supervisor (if required): ______________________________ ______________________________ ____________

PLEASE PRINT NAME & CREDENTIALS — PROVIDE SIGNATURE & CREDENTIALS — **DATE**