Inspiring Minds Inc
Psychiatric Rehabilitation Program

PRP REFERRAL FORM

Date:	Gender:	Male ☐ Female ☐
Client Name (Last, First):		Date of Birth:
Age:	MA:	Social Security:
Home Address:		
City:	State:	Zip:
Parent/Foster/Legal Guardian(Circle One):		
Home Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:

Referral Source Information

Agency Name:	Phone Number:
Referring Worker:	Phone Number:
Address:	Fax Number:

Medical

Primary Care Physician:	Phone Number:
Address:	

Employer/School

Name:	Grade/Position:
Address:	Phone:

Reason for Referral/ Presenting Problems

Rehabilitation Services Needed:

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

Current Treatments: 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:

Diagnosis Given By: _____ ***Date:*** _____

Medications: None

Type:
Type:
Type

Additional Comments/Concerns:

***** Please send or fax this form to our office along with relevant medical records (****Clinic/hospital notes, test, lab or other imaging results, and pertinent consultations. Please include any necessary insurance referral authorizations.* ***Thank you.)***

Referring Provider/Agency Staff Signature: _____

Position/Title: _____ Date: _____
