New Dest Homes

P.R.P. Referral Form

Name_____ Date_____ Sex: M / F / O Race: _____

Address: _____City _____ State ____ Zip _____

Phone # _____DOB_____ SS#_____

MA# _____ Insurance Co: _____

Marital Status S / M / D Education:_____ Veteran?: Y/N Recent Arrest?: Y/N

Minor Parent/Guardian Name _____

Emergency Contact _____ Relationship _____Phone # _____

Address: _____City _____ State ____ Zip _____

PRP eligibility is restricted to the following **ICD-10 diagnoses for Adults (Minors can have any diagnosis)**. Please check all qualifying diagnoses:

- ❑ **F20.9: Schizophrenia**
- ❑ **F20.81: Schizophreniform Disorder**
- ❑ **F25.0: Schizoaffective Disorder, Bipolar Type**
- ❑ **F25.1: Schizoaffective Disorder, Depressive Type**
- ❑ **F28:Other Specified Schizophrenia Spectrum and Other Psychotic Disorder**
- ❑ **F29:Unspecified Schizophrenia Spectrum and Other Psychotic Disorder**
- ❑ **F22:Delusional Disorder**
- ❑ **F33.2:Major Depressive Disorder, Recurrent Episode, Severe**
- ❑ **F33.3:Major Depressive Disorder, Recurrent Episode, With Psychotic Features**
- ❑ **F31.13:Bipolar I Disorder, Current or Most Recent Episode Manic, Severe**
- ❑ **F31.2:Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features**
- ❑ **F31.4:Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe**
- ❑ **F31.5:Bipolar I Disorder, Current or Most Recent Episode Depressed, With Psychotic Features**
- ❑ **F31.0:Bipolar I Disorder, Current or Most Recent Episode Hypomanic**
- ❑ **F31.9:Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified**
- ❑ **F31.9:Bipolar I Disorder, Current or Most recent episode, Unspecified**
- ❑ **F31.9: Unspecified Bipolar and Related Disorder**
- ❑ **F31.81: Bipolar II Disorder**
- ❑ **F21:Schizotypal Personality Disorder**
- ❑ **F60.3: Borderline Personality Disorder**
- ❑ **Other (for Minors only):**

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Reason for PRP Referral (Clinical, please identify specifics):

Self-Care/ Social Skills: Grooming ( ) Personal Hygiene ( ) Nutrition ( ) Food Preparation ( ) Medication ( ) Physical Health ( ) Exercise ( ) Recovery ( ) Wellness ( ) Communication ( ) Peer Support ( ) Family ( ) Community Resources ( ) Activities & Leisure ( ) Other:_____

Independent Living Skills: Home Maintenance ( ) Finances ( ) Transportation ( ) Entitlement ( ) Community ( ) Awareness & Safety ( ) Employment ( ) Adult Education ( ) Shopping ( ) Other:_____

Signs & Symptoms: Mood Swings ( ) Crying Fits ( ) Anger Outbursts ( ) Hallucinations ( ) Fight or Flight ( ) Self Isolation ( ) Grieving ( ) Personality Shift ( ) Focus Problems ( ) Concentration Issues ( ) Other:

_____

Client Goals (Short-Term & Long-Term):

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_____

Therapist Signature: _____ Printed Name & Credentials:_____

Agency Name & Address: _____City_____ State_____ Zip_____

Phone Number:_____ E-mail:_____