Harford Belair Community Mental Health Center, Inc.
Haven Psychiatric Rehabilitation Programs
Referral for Services

Psych Rehab

(Please complete ALL information requested. Submission does not guarantee access to service.)

Patient Name:_____ Today's date:_____

Patient address:_____ City/County:_____ Zip code:_____

Contact phone # for patient:_____

To be completed by Referral source:

Printed Name of Licensed Mental Health Prof. making referral:_____

Signature:_____ **Contact #:_____**

Hospital/Agency:_____ Email address:_____

Who made the diagnosis (circle): Same as above Other:
Who:

INSURANCE INFORMATION:

Medicaid #:_____ Medicare#:_____

Other:_____

Priority Population DIAGNOSIS:
DSM V:_____ ICD9/10(f code):_____
Hx of violence: YES NO
Hx of substance use: YES NO If YES; last use:_____ drug(s) used:

Hospitalized in last year YES NO If YES; where:_____

CURRENT Medications: Is patient adherent: YES NO

Please list any functional living deficits (i.e. homelessness, poor ADL's, etc.):

Legal Involvement:

Conditional Release: YES NO

Probation: YES NO

Parole: YES NO

Rehabilitation Needs:

Patient is aware of referral: YES NO

If currently Inpatient, anticipated date of discharge:

_____

Fax completed form to: 410-426-5247

Questions call: 410-426-1525

PRP REF TRACKER
FOR INTERNAL USE ONLY:

Date rcvd: *by:*
First call attempt: *by:* *result:*
Sec call attempt: *by:* *result:*

Ref source notified: YES NO by: email/phone/letter
Date:
Status: Accepted Rejected Pended Unable to contact