Psych Rehab

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

NPI# of Provider or Agency/Hospital:

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: (list here or attach separate sheet) Is patient adherent: YES NO

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

Are deficits > 2yrs duration? YES NO

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 or Scan/send: sriegger@harfordbelair.org

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