

LIFE SKILLS PRP REFERRAL FORM

Baltimore Location (410-752-6448)  
1645 Ridgely St, Suite 100 Baltimore, MD 21230

Gaithersburg Location (301-527-0701)  
7646 Standish Place Derwood, MD 20855

*For initial referrals, please include the most recent discharge summary and/or progress notes.*

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Client Email: \_\_\_\_\_ Client Address: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_  
If uninsured, has the client applied for MA?  Yes  No

Client Phone: \_\_\_\_\_

Name & Credentials of Referring Clinician:

Agency/NPI:

Phone:

Email Address:

How long treating this individual?  <1mo  2-3mos  4-6 mos  7-12 mos  >1yr

Frequency of treatment:  1x/week  1x/mo  2x/mo  1x/3mos  1x/6mos  Inpatient

**CATEGORY A DIAGNOSES**

**CATEGORY B DIAGNOSES**

- F20.9 Schizophrenia
- F20.81 Schizophreniform Disorder
- F22 Delusional Disorders
- F25.0 Schizoaffective Disorder Bipolar Type
- F25.1 Schizoaffective Disorder Depressive Type
- F25.8 Other Schizoaffective Disorders
- F29 Unspecified Schizophrenia Spectrum & Other Psychotic Dis
- F31.2 Bipolar I Disorder, Current or Most Recent Manic, w/ psychotic features
- F31.5 Bipolar I Disorder, Most Recent Depressed w/ psychotic Features
- F31.64 Bipolar I Disorder, Mixed, Severe w/ psychotic Features
- F33.3 Major Depressive Disorder, Recurrent, w/ psychotic Features

- F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
- F31.13 Bipolar I Disorder, Current or Most Recent Manic Severe
- F31.4 Bipolar I Disorder Current or Most Recent Depressed, Severe
- F31.63 Bipolar I Disorder, Mixed, Severe w/o Psychotic Features
- F31.81 Bipolar II Disorder
- F31.9 Bipolar I Disorder, Unspecified
- F33.2 Major Depressive Disorder, Recurrent, Severe
- F60.3 Borderline Personality Disorder

**CATEGORY A: must meet criteria and select C or D**

**CATEGORY B: must meet criteria and select D**

- C. Currently enrolled in SSI or SSDI.
- D. Demonstrates impaired role functioning for at least 2 years.

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**To qualify for PRP services, client must present with an impaired role functioning, check all that apply:**

**EMPLOYMENT – Inability to gain or maintain employment.**

- Needs vocational support
- Unable to maintain a job for more than 6 months
- Unable to work with others
- Calling out frequently
- Unable to manage time appropriately/efficiently
- Inability to get to work on time or stay the full day
- Receives disability due to mental health diagnosis
- Other: \_\_\_\_\_

**ACTIVITIES OF DAILY LIVING – Challenges in performing necessary skills related to shopping, hygiene, cooking, etc.**

- Unable to live independently and requires oversight for daily living
- Needs assistance/prompting/reminders to complete tasks of daily living
- Needs assistance with shopping, meal prep, medication management, transportation
- Other: \_\_\_\_\_

**SUPPORT SYSTEM– Inability to establish or maintain relationships and connections that foster a sense of support.**

- Inconsistent relationships with others
- Minimal identified supports
- No identified supports
- Social skills limitations

Other: \_\_\_\_\_

**THOUGHT IMPAIRMENT – Difficulty with focus, concentration, retaining information. Needs prompting and/or reminders.**

- Inability to retain information
- Needs reminders and prompting
- Difficulty completing tasks

Other: \_\_\_\_\_

**SELF-CARE – Inability or challenges to independently maintain personal hygiene, make appointments, manage money, etc.**

- Poor hygiene
- Poor oral hygiene
- Poor nutrition
- Other: \_\_\_\_\_

- Unable to coordinate medical care
- Disheveled appearance
- Need for structure

**INITIATION – Inability to plan/organize, carry out goal-directed behavior, etc.**

- Inability to make/follow through with plans
- Difficulty taking initiative
- Lack of organizational skills
- Lack of carrying out goals in the past

Other: \_\_\_\_\_

**COMMUNITY LIVING – Unable to live independently due to limited finances, inability to budget, manage money, etc.**

- Requires assistance to apply for benefits & entitlements
- Requires money management
- Has a rep payee who manages finances

Other: \_\_\_\_\_

**Target Symptoms & Impairments (Check all that apply):**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Depressed mood            | <input type="checkbox"/> Mania                | <input type="checkbox"/> Psychosis                   | <input type="checkbox"/> Poor concentration    |
| <input type="checkbox"/> Obsessive thoughts        | <input type="checkbox"/> Grandiosity          | <input type="checkbox"/> Auditory hallucinations     | <input type="checkbox"/> Sudden weight changes |
| <input type="checkbox"/> Hopeless                  | <input type="checkbox"/> Pacing               | <input type="checkbox"/> Delusions                   | <input type="checkbox"/> Poor judgment         |
| <input type="checkbox"/> Indecisiveness            | <input type="checkbox"/> Impulsive            | <input type="checkbox"/> Disorganized thought/speech | <input type="checkbox"/> Poor stress tolerance |
| <input type="checkbox"/> Lack of motivation        | <input type="checkbox"/> Ruminative thoughts  | <input type="checkbox"/> Paranoia                    | <input type="checkbox"/> Sleep disturbances    |
| <input type="checkbox"/> Loss of interest/pleasure | <input type="checkbox"/> Hypervocal           | <input type="checkbox"/> Responding to internal stim | <input type="checkbox"/> Social isolation      |
| <input type="checkbox"/> Self-injurious behavior   | <input type="checkbox"/> Pressured speech     | <input type="checkbox"/> Visual hallucinations       |  |
| <input type="checkbox"/> Suicidality               | <input type="checkbox"/> Mood instability     | <input type="checkbox"/> Flat affect                 |  |
| <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Anger & Irritability | <input type="checkbox"/> Reduction/poverty of speech |  |
|  | <input type="checkbox"/> Lack of focus        |  |  |
|  | <input type="checkbox"/> Racing thoughts      |  |  |

Other: \_\_\_\_\_

**Signature & Credentials of Referring Clinician:** \_\_\_\_\_

*(By signing, the clinician is recommending PRP services)*