Allen-Ayuk Behavioral Health Center, LLC

Psychiatric Rehabilitation Program (PRP)

ADULT PRP REFERRAL FORM

Please complete form in its entirety; contact our office with any questions.

Name		Gender	○ Male ○ Female ○ Transgender
Address			
Phone	Home: Cell: Work:		
D.O.B.	SSN	MA #	**Active:** Yes No
Race		Marital Status	

LEGAL GUARDIAN/CAREGIVER

Name		Relationship to client	
Contact information *(if different from above)*	Address: Phone:		

CURRENT CLINICIAN/PSYCHIATRIST

Name		Affiliated Clinic	
Address			
Phone	Fax	Email	
How long has client been in treatment with this clinician/psychiatrist?			
Diagnosis *(please include secondary if applicable)*	Primary: Secondary:		
Substance Abuse	○ Yes ○ No *If yes, indicate substance(s) of choice:*		
Suicidal	○ Yes ○ No *If yes, indicate history:*		
Homicidal	○ Yes ○ No *If yes, indicate history:*		

REASON for REFERRAL

Provide a brief description of the reason for referral to PRP. ***Select specific area(s) of need below.***	

Self-Care Skills	Social Skills	Independent Living Skills	Community Living Skills	Symptom Management
Personal Hygiene	Developing supports	Money management	Identifying resources	**Coping Skills for:**
Nutrition	Conflict resolution	Maintaining living env't	Entitlements	Anger
Physical Activity	Boundary awareness	Cooking/Shopping	Housing	Anxiety
Personal Safety	Interactive skills	Time management	Vocational	Grief & Loss
				Other:

REFERRED BY

Print Name & Credentials		Date of Referral	
Signature			

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www.allen-ayukbehavioralhealth.com