|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | | | | Gender | Male Female Transgender | | |
| Address |  | | | | | | | | | | | |
| Phone | Home: Cell: Work: | | | | | | | | | | | |
| D.O.B. |  | | SSN |  | | | MA # | **Active:** Y or N | | | | |
| Race |  | | | | | | Marital Status | | |  | | |
| Attending school? | | Yes No | | | Current School |  | | | | | Grade level |  |

**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.  This section is **necessary**  ***Select specific area(s) of need below.*** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Self-Care Skills**   * Personal hygiene * Nutrition * Physical activity * Personal safety | **Social Skills**   * Developing supports * Conflict resolution * Boundary awareness * Interactive skills | **Independent Living Skills**   * Money management * Maintaining living env’t * Cooking/Shopping * Time management | **Community Living Skills**   * Identifying resources * Entitlements * Housing * Vocational | **Symptom Management**  Coping Skills for:   * Anger * Anxiety * Grief and loss * Other: |

**REFERRED BY**

|  |  |  |  |
| --- | --- | --- | --- |
| Print Name & Credentials |  | Date of Referral |  |
| Signature |  | | |