|  |  |  |  |
| --- | --- | --- | --- |
| 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 |  |