

Instructions: Please PRINT and fax (cover not required) completed form to 410-590-3670, or email to:

referralaa@emrcgroup.org

Information About the Individual Being Referred

First Name, MI, Last Name	Date of Birth	Client's Age
Marital Status	Sex	Race
Home Address (number, street, and apartment number)	Phone Number	
City, State, and ZIP Code	Maryland Medical Assistance, MA, or Medicaid #	
Clinician Name/Organization Name	Social Security Number	
Clinician Address (number, street, and suite number)	Clinician Phone Number	
Clinician City, State, and ZIP code	Clinician Fax Number	

Parent/Guardian Information

Name

Home Address

City, State and Zip

Phone Number

Email Address

Diagnosis: Individuals must have a MHA approved diagnosis to qualify for PRP services in Maryland.

Code	Description
Code	Description
Code	Description

Diagnosis made by:

Date



Presenting Problems, Current Symptoms & Additional Information

Briefly describe individual's current problems, symptoms and needs for community support. Include any information that you feel will assist in determining eligibility and admission into EMRC's PRP.

Services Needed: Individual needs assistance with: *(Check all that apply)*

- | | | |
|---|---|--------------------------------|
| Self Care Skills | Housing Resources/Support | Substance Abuse Support |
| Social Skills | MHVP/Employment Support | |
| Independent Living Skills | Medical Somatic/Health Promotion | |
| Cultural Development | Substance Abuse Issues | |
| Medication Evaluation/Management | Linkage/Accessing Other Services | |
| Education/Behavioral Support | Legal Issues | |

Presenting Behaviors Does minor have an IEP or 504 Plan? Yes No

If so, please provide details

Referral Source Information

Your name and credentials	Phone Number
Organization	Fax Number
Address (number, street, suite number, city, state, and ZIP code)	Email

I am referring this individual to receive Psychiatric Rehabilitation Services from Empowering Minds Resource Center. I believe that there is a reasonable expectation that these services will help this individual to improve and/or maintain independence and current functional level in the community.

Referral Source Signature:

Date: