empowering minds
RESOURCE CENTER

Referral Form

Instructions: Please PRINT and fax (cover not required) completed form to 443-484-2970, or email to: referralhc@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** _____

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

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: _____