THE P3 PURSUIT

P3 PURSUIT, LLC

REFERRAL FOR SERVICES

(Please use this form to refer a person to P3 Pursuit, LLC)

Client Information
Name:
Street Address:
City, State & Zip Code:
Telephone:
Date of Birth:
☐ **You may leave a message at above telephone number.**
☐ **Please do not leave message at above telephone number.**

Referring Agency Information
Name of Agency:
Person Making Referral:
Telephone:
Date of Referral:
☐ **Please contact me immediately for more information.**
☐ **Contact me with an appointment time for the person referred.**
☐ **Contact me if this person does not keep appointment.**

Services Requested	
☐ **Behavioral Health Screening to Determine Need for Further Assessment(s) and/or Treatment**	
☐ **Mental Health Assessment**	☐ **Psychiatric (Medication) Assessment**
☐ **Developmental Disability Assessment**	☐ **Psychiatric Rehabilitation Program**
☐ **Alcohol and/or Drug Abuse Assessment**	☐ **Treatment for:**
☐ **DUI/DWI (Signup on Mondays at 9:00 a.m. — Date: _**	
☐ **Community Engagement (Group/Workshop/School Support)**	

Additional Information about the Person Referred
Specific Problems that Need to be Addressed:

☐ **Suicide Risk:** □YES □NO □N/A

☐ **Danger to Self or Others:** _____

☐ **Urgent/Critical Medical Condition:** _____

☐ **Immediate Threat(s):** _____

☐ **Past Psychiatric Admission(s):** □YES □NO □N/A

☐ **Previous Outpatient Treatment:** □YES □NO □N/A

☐ **Primary Diagnosis:** _____

The more information you can provide us, the better we will be able to help the person you are referring. Please use this space to provide additional information. If possible, include information about symptoms or behaviors that have prompted the referral, stressors affecting the person's ability to function, and natural supports such as family, friends, church, etc., that may support treatment. Please attach additional sheets as necessary.

☐ **Assessment summary with treatment recommendations must be received by this office by:**

Insurance Information	
☐ **Medicaid (MCO_____)**	☐ **Medicaid (#_____)**
☐ **Private Insurance _____**	☐ **Referring Agency**
☐ **Medicare**	☐ **Limited Income: Will need discounted fees**
☐ **Flex Funding Plan**	☐ **Other Payer Source:**

Under state and federal law, information about mental health treatment and substance abuse treatment is confidential and protected. If you would like to receive a copy of the assessment or want to be kept informed of progress in treatment, please ask the person to sign an Authorization to Release Information and Email to: nmckoy@thep3pursuit.com**. If you are referring the client to the PRP program please complete the next section**

MEDICAL NECESSITY CRITERIA
Psychiatric Rehabilitation Program Services (PRP)

Name of Client	**Referring Clinician Signature**
Diagnosis	**Date**

FACTORS OR CRITERIA JUSTIFYING THE NEED FOR PRP SERVICES

The client's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community). Please site examples of dysfunction in one or more life domain.

_____
_____
_____
_____

Based on the clinical evaluation and ongoing treatment plan, PRP services are indicated and are expected to reduce the symptoms of the client's mental illness or the functional behavioral impairment that is a result of the mental illness.

The impairment as a result of the client's mental illness results in: (Please check all that apply)

- ☐ A clear, current threat to the individual's ability to be maintained in his or her customary setting, or
- ☐ An emerging/pending risk to the safety of the individual or others, or
- ☐ Other evidences of significant psychological or social impairment such as inappropriate social behavior causing serious problems with peer relationships and/or family members.
- ☐ Please site examples of impairments._____
  _____
  _____

The individual, due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.

Either:

- ☐ There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the client's symptoms and functional behavioral impairment resulting from the mental illness and restore him or her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the individual or others.
- ☐ Please explain:
  _____
  _____

OR

- ☐ For individuals transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care. Therapist will make referral to PRP program. The client will be connected with an Outpatient Mental Health Center or mental health provider.

☐ Please Explain:_____
_____

☐ The individual's disorder can be expected to improve through medically necessary rehabilitation or there is clinical evidence that this intensity of rehabilitation is needed to maintain the individual's level of functioning; and

☐ The individual is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.

PRP SERVICE REQUIREMENTS

☐ Outpatient mental health services and social supports should be identified and available to the individual outside the program hours and the individual or the individual's parent/guardian should be capable of seeking them when needed when the individual is not attending the rehabilitation program.

☐ There is a documented crisis response plan both inside and outside of program hours coordinated with the primary mental health clinician treating the individual that indicates clear responsibility for the mental health clinician and rehabilitation program.

PLEASE NOTE: In order to initiate service you are required to follow the Three Step Referral Process:

1. Confirm the client is interested in Psychiatric Rehabilitation Day Program Services.
2. Complete the Referral Form.
3. Forward the completed Form. Please use the fax number OR email listed

Requirements for the Referral Process: Based on COMAR regulations

1. Clients that have Medical Assistance may start services within a week of receiving the returned referral information.
2. Clients that have only SSDI and Medicare as their primary are considered uninsured for PRP.

PLEASE NOTE: Presently uninsured clients have no guarantee of authorization from Beacon Health and therefore may take longer to be approved for services. A Licensed Mental Health Professional's signature is REQUIRED on the referral form. In order to establish and maintain eligibility for PRP SERVICES, individuals MUST remain under the care of a psychiatrist and/or therapist while in the program.

Name of Therapist:_____
Name of Agency:_____
Address:_____
Phone:_____ **Email:**_____

Mental Health/Counselor Signature:_____**Date:**_____

**********FOR OFFICE USE ONLY**********
Appointment Date:_____ Time:_____