ASAP DEVELOPMENT CENTER
PSYCHIATRIC REHABILIATION PROGRAM
MINOR REFERRAL FORM

(Submit with a copy of most psychosocial and psychiatric assessments)

Client Information

Last Name: _____ First Name: _____ Middle Itl:_____

Address: _____ Phone:_____

D.O.B.: _____ Grade:_____ Race: _____ Sex: _____ SSN: _____

Medical Assistance #:_____ Access to Transportation for On-Site Activities: □YES □ NO

School or Employer Name: _____ Special Ed/Supported Employment: □YES □ NO

Primary Care Giver Type: □ Parent □ Guardian □ Foster Care Provider □ Residential/Group Home

Does Primary Care Giver have Legal Custody? □ YES □ NO ***(Attach Supporting Documents if Applicable)***

Last Name: _____ First Name: _____ Middle Itl:_____

Address: ***(if different)*** _____ Phone: _____

Referring Agency/Referring Provider Name:

Referring Clinician: _____ Phone: _____ Fax: _____

Referring Agency: _____ Address: _____

Professional Explanation of why PRP Services are needed:

_____

_____

Check All That Apply:

Semi Independent Living Skills: □Taking Care of Belongings □Maintaining Living Area □Safety Skills □Money Management □Mobility Skills □Accessing Entitlements

Interactive Skills: □Interactive w/peers □Interactive w/family □Interactive w/adults □Anger Management

Self-Care Skills: □Personal Hygiene/Grooming □Dressing Self □Toileting □Nutrition/Dietary Planning □Following Routines □Self Administration of Meds

Social Skills: □Community Integration □Participation in activities □Developing Natural Supports

Diagnosis

Diagnosing Clinician: _____ Diagnosis Date: _____

Axis I: Axis II:

Axis III: Axis IV: Axis V:

Length of Time in Treatment/Number of Treatment Episodes: _____ Medications/Dosages: _____

Previous Hospitalizations: (Circle One) □YES □NO Number: _____

Dates:_____

Social Elements Impacting Diagnosis: □None □Educational □Financial □Access to Health Care □Legal System/Crime □Primary Support □Housing □Occupational □Social Environment □Homelessness □Unknown □Other Psychosocial & Environmental *(Attach explanation)*

Signature of Referring Clinician: _____ Date:_____

Co-Signer Signature (for clinicians w/out license): _____ Date:_____