

Key  Point
HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

Dear Fellow Professional,

Thank you for making a referral to Key Point's daytime community psychiatric rehabilitation program. The PRP provides rehabilitation services to psychiatrically disabled adults. Transportation is provided to clients residing in Harford County. Program hours begin at 9am and end at 2pm.

A referral form and Individual Treatment Plan are enclosed. Please fill them out as completely as possible. Type or print neatly. Please do not use "white out."

In order to establish and maintain eligibility for Key Point services, individuals must remain under the care of a psychiatrist while in the program. A psychiatrist's signature is required on the referral form (in part III) and on the Individual Treatment Plan, which prescribes Key Point services. Also future treatment plan reviews will be required every 6 months re-prescribing program services.

Forward completed referral and ITP forms to:
Jeff Bazzett Program Manager, Key Point Health Services
135 North Parke Street
Aberdeen, MD, 21001
Or fax to : attn: Jeff Bazzett 443-625-1540.

When forms are received by Key Point, individuals will be scheduled for an intake appointment. If additional information is needed, please contact Jeff Bazzett at (443) 625-1556 office or (410) 688-8438.

Key Point Health Services Inc PRP/COP Referral Form

I. PROGRAM INTEREST

This client is referred to Key Point for assessment, rehabilitation services and treatment. The referral source and client see needs as:

Please check desired services:

- PRP- Daytime Psychiatric Rehabilitation Program
 COP- Community Outreach Program (*these are off-site PRP services that primarily involve in-home interventions*)
 Both PRP and COP services.

II. DEMOGRAPHIC INFORMATION

Name _____ Referral Date _____

Address _____

Phone Number _____ DOB _____ Age _____

Marital Status _____ Birth Place _____ Sex _____

Income Source _____ Amount _____

Insurance Type _____ Policy # _____

Education _____ Social Security \$ _____

Emergency Contact: _____ Phone Number _____

Address: _____

Referral Source/ Person _____ Phone # _____

III. PSYCHIATRIC INFORMATION (Diagnosis- provide DSM-IV code number and name)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V. _____

Name of Therapist: _____ Phone # _____

Somatic Physician _____ Phone # _____

Address _____

Description of physical illness/medications: _____

Does the client have special dietary needs? _____

Date and place of most recent physical exam: _____

V. PERSONAL PSYCHOLOGICAL ASSETS/COMMENTS: please be as specific as possible.

**KEY POINT HEALTH SERVICES, INC
INDIVIDUAL TREATMENT PLAN (ITP)**

Patient's Name _____ ITP Date _____

Current Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Current medications: (please specify name of drug, strength and dosage schedule)

Present goals and methods:

Progress towards goals:

Referral to Key Point's PRP for assessment and rehabilitation services, and treatment.

(Check all that apply)

<input type="checkbox"/> Independent living skills development	<input type="checkbox"/> Social skills Development
<input type="checkbox"/> Leisure/ Recreation Skills Development	<input type="checkbox"/> Socialization Opportunities
<input type="checkbox"/> Work Skills development	<input type="checkbox"/> Other

I, the treating physician, submit this ITP based on rehabilitation needs determined after at least one face to face interview with patient.

Patient's Signature Date

Therapist's Signature Date

Psychiatrist's Signature Date