Key Point
HEALTH SERVICES INC.
OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

REFERRALS TO THE KEY POINT HARFORD COUNTY PRP

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

A referral form is attached. Please fill it out as completely as possible. The form needs to be signed by a licensed mental health professional.

Please provide us with your contact information and that of the treating licensed therapist (if any). Feel free to add any additional narrative you might wish to provide that would assist us.

If you happen to be a family member, friend, or a potential client -- please take this form to a treating mental health professional. We are however very happy to directly answer your questions about our PRP and the mental health system in general. Please also see our blog and website at http://prp.keypoint.org .

In order to establish and maintain eligibility for Key Point services, individuals must remain under the care of a psychiatrist and licensed therapist while in the program. Future reauthorizations by the licensed therapist or psychiatrist will be required every six months.

Forward completed referral forms to:

Alisha Simmons
Program Manager
Key Point Harford County PRP
135 North Parke Street
Aberdeen, MD 21001
PH: 443-625-1556 : FAX: 443-625-1540

Questions may be directed to Alisha Simmons at 443-625-1556 or alishasimmons@keypoint.org .

When forms are received by Key Point, individuals will be scheduled for an intake appointment.

Key Point Health Services
Community Outreach and PRP Day Program REFERRAL Form

Client Name: _____ MA#: _____
Address: _____
Phone #_____DOB:_____Race: _____
I am referring the patient for the following services: ☐PRP Day Program ☐In Home Offsite COP
This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to the form.

Axis I:

☐295.10-Schizophrenia, disorganized
☐295.20-Schizophrenia, catatonic
☐295.30-Schizophrenia, paranoid
☐295.40-Schizophrenifrom disorder
☐295.60-Schizophrenia, residual
☐295.70-Schizoaffective disorder
☐295.90-Schizophrenia, undifferentiated
☐296.33-MDD, severe w/o psychosis
☐296.34-MDD, severe with psychosis
☐298.90-Psychotic Disorder NOS
☐296.43-Bipolar I, Most recent manic, w/o psychosis
☐296.44-Bipolar I, most recent manic, with psychosis
☐296.53-Bipolar I, most recent depressed, w/o psychosis
☐296.54-Bipolar I, most recent depressed with psychosis
☐296.63-Bipolar I, most recent missed w/o psychosis
☐296.64-Bipolar I, most recent mixed with psychosis
☐296.80-Bipolar Disorder NOS
☐296.89-Bipolar II Disorder
☐297.10 Delusional Disorder

Axis II:

☐301.22-Schizotypal Personality Disorder
☐301.83-Borderline Personality Disorder

Axis III: _____

Axis IV: _____

Axis V GAF: _____
If client does not have Medical Assistance: SS#_____
This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years: Yes☐ No☐

Individual experiences at least three of the following:

☐Inability to maintain independent employment
☐Social behavior that results in interventions by the mental health system
☐Inability to procure financial assistance due to cognitive disorganization
☐Severe inability to establish or maintain social supports
☐Need or assistance with basic living skills

Current Medications: _____
Is the individual med compliant: ☐yes ☐no

Presenting Symptoms: Please include hx of SI and HI

_____
_____

Criminal Hx- ☐yes ☐no
Reason for Referral:

1) **Self-care skills-** ☐personal hygiene, ☐grooming, ☐nutrition, ☐dietary planning, ☐food preparation, ☐self administration of medication.
2) **Social Skills-** ☐community integration activities, ☐developing natural supports, ☐developing linkages with and supporting the individual's participation in community activities.
3) **Independent living skills-** ☐skills necessary for housing stability, ☐community awareness, ☐mobility and transportation skills, ☐money management, ☐accessing available entitlements and resources, ☐supporting the individual to obtain and retain employment, ☐Health promotion and training, ☐ndividual wellness self management and recovery.

_____ _____
Mental Health Professional Signature and Credentials **Date**

_____ _____
Referring Professionals Name **Address and Phone (Only for Providers outside of Key Point)**
Revised 11/12 - sm