

Centers for Behavioral Health, LLC
Life Skills PRP - Referral Form

Date _____

1645 Ridely Street, Suite 100
Baltimore MD 21230
Phone: 410-752-6448
Fax: 410-752-5065

Client Name _____ **DOB** _____ **SSN** _____
Client Phone _____ **Insurance** _____ **Policy #** _____
If no insurance, has consumer applied for Medical assistance Yes _____ No _____
Address _____ **Email:** _____
Name & Credentials of Licensed Referring Clinician _____

Name of Agency / Facility _____

Must have one of the following diagnoses:

AXIS I

- Schizophrenia 295.90 / F20.9
- Schizophreniform Disorder 295.40 / F20.81
- Schizoaffective Disorder, Bipolar Type 295.70 / F25.0
- Schizoaffective Disorder, Depressed Type 295.70 / F25.1
- Other Specified Schizophrenia Spectrum & Other Psychotic Disorder 298.8 / F28
- Unspecified Schizophrenia Spectrum & Other Psychotic Disorder 298.9 / F29
- Delusional Disorder 297.1 / F22

- Major Depressive Disorder, Recurrent Episode, Severe 296.33 / F33.2
- Major Depressive Disorder, Recurrent, With Psychotic Features 296.34 / F33.3

- Bipolar I Disorder, Current or Most Recent Episode Manic, Severe 296.43 / F31.13
- Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features 296.44 / F31.2
- Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe 296.53 / F31.4
- Bipolar I Disorder, Most Recent Episode Depressed with Psychotic Features 296.54 / F31.5
- Bipolar I Disorder, Current or Most Recent Episode Hypomanic 296.40 / F31.0
- Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified 296.40 / F31.9
- Bipolar I Disorder, Current or Most Recent Episode Unspecified 296.7 / F31.9
- Unspecified Bipolar and Related Disorder 296.80 / F31.9
- Bipolar II Disorder 296.89 / F31.81

AXIS II

- Schizotypal Personality Disorder 301.22 / F21
- Borderline Personality Disorder 301.83 / F60.3

PRESENTING PROBLEMS/REASON FOR REFERRAL: (Please select up to 5 areas)

- | | |
|---|--|
| <input type="checkbox"/> Appointment Assistance | <input type="checkbox"/> Need for Higher Level of Mental Health Care |
| <input type="checkbox"/> Case Management Needs | <input type="checkbox"/> Need for Structure |
| <input type="checkbox"/> Cognitive Difficulties | <input type="checkbox"/> Safety Concerns in the Community |
| <input type="checkbox"/> Community Integration Difficulties | <input type="checkbox"/> Social Skills Limitations |
| <input type="checkbox"/> Housing Needs | <input type="checkbox"/> Substance Use Concerns |
| <input type="checkbox"/> Impulse Control Concerns | <input type="checkbox"/> Symptom Management |
| <input type="checkbox"/> Independent Living Limitations | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Limited Social Support | <input type="checkbox"/> Vocational Skills Limitations |
| <input type="checkbox"/> Medication Assistance | |

Signature of Licensed Referring Clinician _____