WIN Team

We Don't Give Up On Families"

Referral Form

Client Name: _____ **Medical Assistance #:** _____

SSN:_____ **M or F** **Ethnicity:** _____ **DOB:**_____ **Age:** ____

Address: _____ **City:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Legal Guardian (if applicable): _____ **Relationship (to client):** _____**Phone**_____

REASON FOR REFERRAL (check all that apply):

☐Behavior/Conduct Challenges ☐Emotional/Mental Illness ☐ Employment Instability ☐Financial Instability

☐Legal/Incarceration ☐Medication Mismanagement ☐Physical/Emotional Abuse ☐Relational Conflicts

☐Sexual Abuse ☐Social/Interpersonal Challenges ☐Substance Abuse ☐Suicidal/Homicidal

PRP SERVICES REQUESTED (check all that apply):

☐Adaptive Resources ☐Crisis Intervention ☐Dangerous Behaviors ☐Education/Vocational Training ☐Health Promotion

☐Independent Living Skills ☐Promotion of Wellness, Self-Management, & Recovery ☐ Recovery Challenges

☐Psychiatric Inpatient/Detention Center Support ☐ Self-Care Skills ☐Social Relationships & Leisure Activities

☐Social Skills

SYMPTOMS AND BEHAVIORS/RISK BEHAVIORS (check all that apply):

☐Anxiety/Panic ☐Attachment Problems ☐Depressed ☐Fire Setting ☐Homicidal Ideations ☐Hopeless/Helpless

☐ Hyperactive ☐Impulsive ☐Irritable ☐Isolative ☐ Lying/Manipulative ☐Manic Mood ☐Obsession/Compulsion

☐Oppositional Defiant ☐Physical Aggression ☐Property Destruction ☐Running Away ☐Self-Care Deficit

☐Self-Injurious Behavior ☐Separation Problems ☐Sexually Inappropriate ☐Social/Withdrawal ☐Stealing

☐Suicidal Ideations ☐Trauma-related ☐Truancy ☐ Verbal Aggression

Please indicate current DSM IV diagnoses & relevant medications: (Each Axis must be completed, as well as GAF)

Axis I: _____ **Medications** _____

Axis II: _____ **Medications:** _____

Axis III: _____ **Medications:** _____

Axis IV: _____ **Medications:** _____

Axis V: _____ **Medications:** _____

Diagnosis given by: _____ **Date:** _____

Is there documentation attached to verify this diagnosis? ☐ **YES** ☐ **NO**

Is the client currently receiving therapy? ☐ **YES** ☐ **NO**

Treating Therapist: _____ **Date:** _____**Phone:** _____

Therapist Signature: _____ **(MUST BE A LICENSED THERAPIST)**

☐ Verbal Approval from Therapist to refer identified client for Psychiatric Rehabilitation services secured.

☐ I am authorized or have been given authorization to give consent for WIN Team PRP to collaborate with service providers to receive and verify the information on this form for screening assessment purposes, and to determine the appropriateness of services for above-referenced individual.