

**WICOMICO BEHAVIORAL HEALTH
108 East Main Street
Salisbury, MD 21801
410-334-3497**

**CONSENT FOR PRP SERVICES
AND RELEASE OF INFORMATION**

Name _____ Date of Birth _____

Address _____

Telephone Number _____

Referring Agency _____

Agency Contact Person _____ Phone _____

Consent to Services:

I understand that I am applying for PRP services at Wicomico County Health Department. I acknowledge that I have been offered a choice of PRP providers that serve the area and I wish to receive PRP services from Wicomico County Health Department. I agree to receive these services if approved and to participate in the development of a Rehabilitation Plan, which I will be asked to sign. I understand that I may revoke my consent to services at any time by written or verbal request.

Consumer Signature (or guardian) _____ Date _____

Witness _____ Date _____

I authorize the above referenced provider to furnish to Wicomico Behavioral Health's PRP, the information requested on the referral in order to make a determination of eligibility for PRP services. If found eligible for services, I further authorize the release of this information to the Wicomico County Health Department's PRP for full screening and service eligibility determination and to MAPS-MD to determine eligibility for PRP services. I understand that I may revoke my permission at any time by written or verbal request.

Consumer Signature (or guardian) _____ Date _____

Witness _____ Date _____

**WICOMICO BEHAVIORAL HEALTH
PSYCHIATRIC REHABILITATION PROGRAM
REFERRAL FORM**

C&A _____ ADULT _____

CLIENT INFORMATION:

Last Name: _____ First Name: _____ M.I. _____

Address: _____
(Street) (City) (State) (Zip)

Phone Number: _____

PARENT OR GUARDIAN INFORMATION:

Last Name: _____ First Name: _____ M.I. _____

Address: _____
(Street) (City) (State) (Zip)

INSURANCE INFORMATION: Type: _____ Number: _____

If no insurance, have you applied for Medical Assistance? _____ Yes _____ No _____

Subscriber: _____ Relationship: _____

MENTAL HEALTH TREATMENT PROVIDER:

Name: _____ Agency: _____

Phone: _____ FAX: _____

MENTAL HEALTH DIAGNOSIS:(please attach MSE if available)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

DATE OF DX AND WHO DIAGNOSED: _____

CURRENT MEDICATION:

MEDICATION COMPLIANT: Y or N

PRP REFERRAL FORM

REASON FOR PRP REFERRAL:

CURRENT OUTPATIENT TREATMENT:

(Modality type and frequency)

PRIOR TREATMENT INCLUDING INPATIENT:

OMHC, PRP, Group Home, Respite, Hospitalizations

(Dates, name of providers, why treated there):

RISK:

Homicidal or Suicidal, thoughts, ideation, plan, attempts (describe in detail with *safety measures* in place):

Any other patient risk to community:

MEDICAL:

Last Physical: _____ Medical Conditions: _____

Medical Doctor: _____

SOCIAL SUPPORT:

(Social network, activities, religious, spiritual or other support):

PRP REFERRAL FORM**LEGAL PROBLEMS:**

SUBSTANCE USE:

(Duration, amount, frequency, last use etc.):

SCHOOL/EMPLOYMENT:

School/EmployerName: _____

Address: _____

(Street)(City)

(State)

(Zip)

Phone: _____ Grade Level: _____ Grades _____

Behaviors in School: _____

Special Education/Supported Employment _____ Yes _____ No _____

Learning Disabilities: _____

Comments: _____

FAMILY:

Residence: Private Home with Relatives _____ Foster Care/Project Home _____

Group Home/Assisted Living _____

Household Functioning:(Financial, Interpersonal, Condition of Home, Quality of Support Systems,
Involvement of Family in Treatment):

Referral to PRP by: _____

(Name)

(Agency)_____
(Date)**** Please attach most recent MSE along with the referral form, if it is available**

REVISED: 9/6/2007