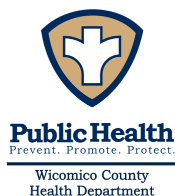

Wicomico County Health Department
108 East Main Street • Salisbury, Maryland 21801
Brandy Wink, Acting Health Officer

WICOMICO BEHAVIORAL HEALTH
CONSENT FOR PRP SERVICES
AND RELEASE OF INFORMATION

Name: Date of Birth:

Address:

Home Telephone Number: Cell 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 my insurance company 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.:

Date of birth: Address:

Home telephone number: Cell number:

PARENT OR GUARDIAN INFORMATION:

Last Name: First Name: M.I.:

Address:

Home telephone number: Cell number:

Has legal custody or guardianship been established? If yes, please attach court order.

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:

DSM-5 MENTAL HEALTH DIAGNOSIS:(please attach current MSE if available)

DATE OF DIAGNOSIS AND WHO DIAGNOSED:

CURRENT MEDICATION:

MEDICATION COMPLIANT: ☐ Yes ☐ No
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, reason for treatment)

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):

LEGAL PROBLEMS:

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

SCHOOL/EMPLOYMENT:
School/Employer Name:
Address:
Phone: Grade Level: Grades:

Behaviors in School:

Special Education/Supported Employment ☐ Yes ☐No

Learning Disabilities:

Comments**:**

<u>FAMILY</u>:
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**:** ______________________________
(Printed Name with credentials) (Signature with credentials)

(Agency) (Date**)**

____
Signature of clinical supervisor with credentials, if referrer is not independently licensed

**** Please attach most recent MSE and ITP along with the referral form, if it is available**

REVISED: 2/22/2023