Village Behavioral Health Center

5526 Belair Road, Baltimore, MD 21206 • (443) 759-4184 • admin@villagebhcenter.com

Adult Psychiatric Rehabilitation Program (PRP) Referral

Date of referral: _____

Please complete all sections. Referrals must come from a Maryland Medicaid–enrolled licensed mental health professional who currently provides mental health treatment to the client (COMAR 10.09.59).

1 CLIENT INFORMATION

Client name: _____ Date of birth: _____

Address: _____

City / ZIP: _____ Phone: _____

Medicaid ID (MA #): _____ Preferred language: _____

Emergency contact / relationship: _____ Phone: _____

Best way to reach client: ☐ Phone ☐ Text ☐ Through referring provider

2 REFERRING PROVIDER

Name & credentials: _____ NPI: _____

Agency / practice: _____

Phone: _____ Fax: _____ Email: _____

Services you currently provide this client: ☐ Outpatient ☐ Inpatient ☐ RTC

Date of most recent visit: _____ Visit frequency: _____

☐ I am actively enrolled with Maryland Medicaid as an individual practitioner or ORP provider.

3 DIAGNOSIS

Primary diagnosis (ICD-10 code & description): _____

Secondary diagnosis(es): _____

Primary diagnosis must be a specialty mental health diagnosis within the PBHS priority population.

4 REASON FOR REFERRAL

Current functional impairment due to mental illness (check all that apply):

☐ Clear, current threat to the client's ability to live in their customary setting

☐ Unable to work or attend school without support

☐ Unable to manage the effects of their mental illness without support

Describe the skills the client needs to develop or restore (e.g., daily living, medication management, community resources, social skills):

_____

_____

_____

Less intensive services tried, and why they were unsafe or unsuccessful:

_____

_____

5 TREATMENT & SAFETY

Current medications / prescriber: _____

Psychiatric hospitalizations in the past 12 months (dates): _____

Current safety concerns? ☐ No ☐ Yes (describe below)

_____

Client lives in a Residential Rehabilitation Program (RRP)? ☐ No ☐ Yes

6 INFORMED CHOICE & SIGNATURES

☐ I informed the client of their choice of PRP providers, and the client chose Village Behavioral Health Center.

☐ The client agrees to this referral and to being contacted by VBHC.

☐ The client does not currently require a more intensive level of care.

Referring provider signature: _____ Date: _____

Client signature (optional): _____ Date: _____

How to submit: email the completed form and any recent assessment or treatment notes to admin@villagebhcenter.com with the subject line “PRP Referral.” Please use secure (encrypted) email. Questions? Call (443) 759-4184, open daily 8:00 AM – 8:00 PM.