Dear Referring Professional,

Attached is the Referral Form required to receive PRP services from McGuire Therapeutic Services. Please complete the referral form and attached forms for us to accept and process the referral. The following information is attached:

PRP Referral Form
A list of accepted priority population diagnoses for PRP services
Authorization for the Release of Information Form

Please fax the above information to my attention at (844) 612-7917. Upon its receipt, I will contact you to schedule an intake appointment. Please feel free to contact me at 301-731-1222 or email info@mcguiretherapy.com with any questions. I look forward to working with you.

Sincerely,
McGuire Therapeutic Services
Psychiatric Rehabilitation Specialist

Psychiatric Rehabilitation Program
PRP REFERRAL FORM

Name		Gender	Male Female Transgender
Address			
Phone		Home: Work:	Cell:

D.O.B.SSNMA # **Active:** Y or NRace

	Marital Status		
Employment		Highest level of education	
Veteran Yes/No		Number of Arrests in last 30 days:	
Name of PCP:			

REASON FOR REFERRAL (check all that apply):

___Behavior/Conduct Challenges	___Emotional/Mental Illness	___Employment /Financial Instability
___Housing	___Medication Mismanagement	___Suicidal/ Homicidal
___Relational Conflicts	___Social Skills	___Substance Abuse
___ Community Living Skills	___Self Care Skills	___ Independent Living Skills
___ Sexual/Physical/Emotional Abuse	___ Symptom Management	___ Legal/Incarceration

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

___Anxiety/Panic	___Depressed	___Homicidal Ideations	___Hopeless/Helpless
___Self-Injurious Behavior	___Trauma-related	___Verbal/Physical Aggression	___Self-Care Deficit
___Social/Withdrawal	___Sexually Inappropriate	___Suicidal Ideations	___Stealing
___Property Destruction	Impulsive/Manic Episode	___Irritable	___Lying/Manipulative

Suicide Risk	Yes No	Danger to Self or Others	Yes No	Urgent/ Critical Medical Condition	Yes No	Immediate Threat(s):	
Past Psychiatric Admission(s):	YES NO N/A			Previous Outpatient Treatment	YES NO N/A		

DSM V DIAGNOSES & RELEVANT MEDICATIONS:

Axis I:	Axis II:	Axis III:	Axis IV:

Medications:	

Is there documentation attached to verify this diagnosis? YES NO	Is the client currently receiving therapy? YES NO
Referral Source Printed Name & Agency (IF APPLICABLE):	
Signature:	Date of Referral:
Phone:	Email:

CHECK APPLICABLE:

___ 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 McGuire Therapeutic Services 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

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Priority Population Diagnoses – Adults

The following is a list of accepted Priority Population Diagnoses listed below as the ***primary diagnosis (es)*** for the applicant.

DSM-5 Diagnosis	ICD-9 CODE	ICD-10 CODE
Schizophrenia	**295.90**	**F20.9**
Schizophreniform Disorder	**295.40**	**F20.81**
Schizoaffective Disorder, Bipolar Type	**295.70**	**F25.0**
Schizoaffective Disorder, Depressive Type	**295.70**	**F25.1**
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	**298.8**	**F28**
Unspecified Schizophrenia Spectrum and 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 Episode, with Psychotic Features	**296.34**	**F33.3**
Bipolar I Disorder, Current or Most Recent Episode, Manic	**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, Current or 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**
Schizotypal Personality Disorder	**301.22**	**F21**
Borderline Personality Disorder	**301.83**	**F60.3**

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ fully authorize McGuire Therapeutic Services to release/receive information regarding my Healthcare to:
Name/Agency: _____ Relationship to Client: _____

Address:
_____
_____

City, State, Zip: _____Phone# _____ Fax # _____
For the following purposes:
▫ Copies of Records ▫ Discharge Summaries ▫ Consultation ▫ Treatment Planning
▫ Medication Information ▫ Diagnostic Information ▫ Financial/ Benefits Information
▫ Discharge/Follow-up Care ▫ Necessary Rehabilitation Information ▫ Other/ Relevant Information _____

The information will be communicated via_____ Telephone_____
Correspondence and is authorized to be
Communicated both ways_____ Yes_____ No.
The requested information will be used to help _____formulate psychiatric rehabilitation goals and _____
Coordinate treatment across my healthcare team.
I know that this authorization is voluntary, and will not affect my healthcare and payment if I refuse to sign it.
I understand that I may review the requested information, request and keep upon receipt, a copy of this authorization after I sign it.
I understand that the information provided by this request will be held in the strictest of confidence and is to be used only by the professionals on my healthcare team.
This authorization can be cancelled by me at any time, unless a process has already started and its completion depends of this authorization.
Signature: _____
Date:_____

Expires on: _____ (One year from today)

Witness: _____ Date: _____

9320 Annapolis Road Suite 340 Lanham, MD 20706 Phone 301- 731-1222 Fax 1(844)-612-7947
www.mcguiretherapy.com

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