INNERSOURCED SOLUTIONS, LLC

Adult Psychiatric Rehabilitation Program

Referral Form

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services.

Email to: Admin@InnerSourcedSolutions.com

DEMOGRAPHIC INFORMATION:				
Name:			Referral Date:	
Address:				
Phone Number (best and alternate):				
DOB:	SS#:			
Medical Assistance # (if uninsured, note if an application is pending):				
Gender:	Race(s):			
Marital Status:	Veteran?	☐ Yes	☐ No	
Highest Level of Education:	Employment Status:			
Primary Language*:	Secondary Language:			

*** InnerSourced Solutions, LLC only provides services for English speaking patients at this time.**

If Patient has no insurance, one of the following Grey Zone eligibility criteria must be checked:

☐ Homeless ☐ SSDI for mental health reasons ☐ Referred by order of a Conditional Release
☐ Received services in the public mental health system within the 2 years
☐ Discharged from a Maryland psychiatric hospital or residential crisis bed within the past 3 months
☐ Released from Dept. of Corrections/prison/jail within the past 3 months

HISTORY OF PSYCHIATRIC HOSPITALIZATIONS: ☐ Yes ☐ No

If yes, please indicate facilities and dates of service: *Please attach discharge summary if available.*

HISTORY OF COURT CHARGES AND INCARCERATIONS (check where applicable):
☐ Drug-Related ☐ Theft ☐ Assault ☐ Weapons Possession ☐ Sexual* ☐ Other

*Is patient currently registered as a sex offender ☐ yes ☐ no

Number of arrests in the past 90 days:

ADDITIONAL CONTACTS:

Name	Phone Number
Primary Care Physician:	
Psychiatrist:	
Therapist:	
Case Manager:	

Referral source: Is this a self-referral? ☐ Yes ☐ No If no, please complete the following information and attach a signed release so that we may contact you for follow-up if needed.

PRIMARY DSM-5 DIAGNOSIS

(NOTE*: Eligibility for PRP services is restricted to the following DSM-5 diagnoses*):

☐ F20.9 Schizophrenia	☐ F31.13 Bipolar I Disorder, Current or most Recent Episode Manic, Severe
☐ F20.81 Schizophreniform Disorder	☐ F31.2 Bipolar I Disorder, Current or most Recent Episode Manic, Severe, with Psychotic Features
☐ F25.0 Schizoaffective Disorder, Bipolar Type	☐ F31.4 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe
☐ F25.1 Schizoaffective Disorder, Depressive Type	☐ F31.5 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe with Psychotic Features
☐ F28 Other Specified Schizophrenia Spectrum or Other Psychotic Disorder	☐ F31.0 Bipolar I Disorder, Current or most Recent Episode Hypomanic
☐ F29 Unspecified Schizophrenia Spectrum of Other Psychotic Disorder	☐ F31.9 Bipolar I Disorder, Unspecified
☐ F22 Delusional Disorder	☐ F31.81 Bipolar II Disorder,
☐ F33.2 Major Depressive Disorder, Recurrent Episode, Severe	☐ F21 Schizotypal Personality Disorder
☐ F33.3 Major Depressive Disorder, Recurrent Episode, Severe with Psychotic Features	☐ F60.3 Borderline Personality Disorder

MEDICAL DIAGNOSES (ICD 10):	
Diagnosis Code #1:	Diagnosis #2:
Diagnosis Code #3:	Diagnosis #4:

SOCIAL ELEMENTS IMPACTING DIAGNOSTIC (check all that apply)	
☐ None	☐ Educational
☐ Problems with Access to Healthcare Services	☐ Financial
☐ Problems Related to Interactions with Legal System / Crime	☐ Problems with Primary Support Group
☐ Housing Problems (Not Homelessness)	☐ Occupational problems
☐ Problems Related to the Social Environment	☐ Homelessness
☐ Other Psychosocial and Environmental Problems	☐ Unknown

FUNCTIONAL ASSESSMENT:	
Assessment Measure:	Score:
Inpatient Psychiatric Hospitalizations (within the past six months):	
Legal Involvement (within the past six months):	
Summary of ITP Goals:	

This individual has a serious mental illness which is required the intervention of the Public Mental Health System in the last two Years ☐ Yes ☐ No

Individual experiences at least three of the following:

☐ Inability to maintain independent employment
☐ Social behavior that results in interventions by the mental health system
☐ Inability to procure financial assistance to support living in the community due to cognitive disorganization
☐ Severe inability to establish or maintain social supports
☐ Need for assistance with basic living skills

MEDICATIONS (If Known):		
Medication Name	Dosage/Frequency	Prescribing Physician

PATIENT AGREEMENT:

I wish to be considered for PRP services with InnerSourced Solutions, LLC.

Client Signature	Date

Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided by Inner Sourced Solutions, LLC. This referral must be signed by the clients **treating** psychiatrist, nurse practitioner, or licensed mental health practitioner.

I, _____ refer _____
(Treating Clinicians Name & Credentials) (Print (Consumer's Name)

_____ _____
(Clinician's Phone Number) (Clinician's Email Address)

Please include copy of most recent:	Patients should bring to their first visit:
• Discharge summary • Physical exam List of current medications	• Identification • Health insurance card • If the patient is a minor, please bring immunization records.

INNERSOURCED SOLUTIONS, LLC

Authorization to Disclose Health Information/Release of Information

Name:	
Address:	
Phone Number (best and alternate):	
DOB:	SS#:

I authorize the use or disclosure of the above-named individual's health information as described below:

The following individual or organization is authorized to:

☐ release the information

☐ receive and use the information

Individual/Organization Name:
Address:
Phone:
Fax:

The following individual or organization is authorized to: ☐ release the information ☐ receive and use the information:

InnerSourced Solutions, LLC
3261 Old Washington Road, Suite 2020
Waldorf, MD 20602-3231
Phone: 240-207-4513
Fax: 240-846-6037

The purpose(s) for which the information may be released:
☐ At the request of the patient
☐ Continuation of care/consultation
☐ Social Security/Disability Certification
☐ To pass on message to the patient; determine the patient's location
☐ To exchange information concerning the patient illness and treatment
☐ Other:

_____

If not previously revoked, this authorization will terminate on the earliest of the following dates: One year from the signatures date below, or upon the following date, event, or condition:

_____

(For authorizations to terminate due to an event or condition, the parties authorized to release information above must be notified in writing upon occurrence of the event or condition to cancel authorization.)

What information is being released:
Items below may include information on substance abuse and HIV/AIDS status unless indicated otherwise here:

☐ Do not disclose substance abuse information	☐ Most Recent History and Physical
☐ Do not disclose HIV information	☐ Referral
☐ Emergency Room Record	☐ Immunization Record
☐ Entire record except psychotherapy notes	☐ Intake Interview
☐ Medication List	☐ Psychosocial Assessment
☐ Psychiatric Evaluation/Diagnosis	☐ Verbal Communication
☐ Discharge Summary	☐ Most Recent Physical Exam
☐ Psychological/Educational Report	☐ Other _____

☐ Psychotherapy Notes (Due to the highly sensitive nature of psychotherapy notes federal law requires a separate authorization form for their disclosure.)

Dates of information (it applicable): From:_____to _____

In understand the following:
A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

Revocation: I have the right to revoke this authorization at any time. If I choose to cancel the release of information/authorization, I must notify the person/company identified in Section B in writing that I revoke this authorization. The revocation will not apply to information that has already been released in response to this authorization.

Re-disclosure: If this information is to be received by individuals or organizations that are not health care providers, health care clearing houses, or health plans covered by federal privacy regulations, my information described above may be re- disclosed and no longer protected by federal privacy regulations. Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws.

Conditioning of eligibility: InnerSourced Solutions, LLC will not withhold treatment from me if I refuse to sign this form.

Signature: _____ **Date:** _____
Patient, Parent, Legal Guardian

Authorizations signed by a legal representative must include a copy of the Guardianship papers or a Power of Attorney.

Witness (if client is unable to sign):

Signature:_____Date: _____