Email to: Admin@InnerSourcedSolutions.com

InnerSourced Solutions, LLC

Child & Adolescent
Psychiatric Rehabilitation Program Referral

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

DEMOGRAPHIC INFORMATION:			
Name:			Referral Date:
Parent/Legal Guardian Name:			
Address:			
Phone Number (best and alternate):			
DOB:	SS#:		
Medical Assistance # (if uninsured, note if an application is pending):			
Gender:	Race(s):		
Highest Level of Education:	Employment Status:		
Primary Language*:	Secondary Language:		

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

DSM 5 DIAGNOSIS:
Primary Diagnosis:
Additional Diagnosis:

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

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

Presenting Symptoms: Please include history of SI and/or HI ideations and/or judicial involvement including Child Protective Services or Department of Juvenile Justice:

Reason for referral:

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Risk for Aggressive Behaviors, Suicide, or Homicide: ☐ N/A ☐ Yes, (explain):

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Social Elements Impacting Diagnosis: (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):	

ADMISSION CRITERIA – Verify that all of the following admission criteria are met.

1. Client has a PMHS specialty mental health diagnosis and the individual's impairment(s) and functional behavior is expected to improve with these services.
2. The minor's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community)
3. The impairment as a result of the youth's mental illness results in:

- A clear, current threat to the Individual's ability to be maintained in his/her customary setting, or
- An emerging/pending risk to the safety of the Individual and others, or

- Other evidence of significant psychological or social impairments such as inappropriate social
- Behavior causing serious problems with peer relationships and/or family members.

4. The Individual, due to the dysfunction, is at risk for requiring a higher level of care or is returning from a higher level of care.
5. The Individual's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the Individual's recovery.
6. The Individual does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.
7. A documented crisis response plan for the Individual is in progress or completed.
8. An Individual Rehabilitation Plan (IRP) is in progress or completed.
9. PRP services will be rendered by staff that is supervised by a licensed mental health professional.

And either:

There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the youth's symptoms and functional behavioral impairment resulting from the mental illness and restore him/her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the Individual or others; or

For Individual transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community or avert the need to initiate or continue a more intensive level of care.

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 a **treating** psychiatrist, nurse practitioner, or licensed mental health practitioner.

I, ____, refer ____________________________

(Treating Clinician's Signature & Credentials) (Print Consumer's Name)

____ ____________________________

(Print Clinician's Phone Number) (Clinician's Email)

Attach: Current Individualized Treatment Plan & Clients Immunization