

Channel Marker, Inc.

8626 Brooks Drive, Unit 304, Easton, MD 21601
Phone: 410.822.4619

REFERRAL – ADULT SERVICES

PLEASE SEND REFERRAL TO:

- | | | |
|---|--|--|
| <input type="checkbox"/> Channel Marker, Inc.
Caroline County Program
508 Kerr Avenue
Denton MD 21629
410.479.2318 – phone
410.820.0124 - fax
ATTN: County Director | <input type="checkbox"/> Channel Marker, Inc.
Dorchester County Program
420 Dorchester Avenue
Cambridge MD 21613
410.228.8330 – phone
410.221.6459 - fax
ATTN: County Director | <input type="checkbox"/> Channel Marker, Inc.
Talbot County Program
222 Port St.
Easton MD 21601
410.822.4611 – phone
410.822.6186 - fax
ATTN: County Director |
|---|--|--|

To Be Completed by Referral Source

Channel Marker, Inc. requests clinical information from your agency in order to obtain APS authorization to process each referral.

Please mail or fax the following as available:

- _____ Current Mental Health Treatment Plan (ITP)
 - _____ Current Social History/Intake/Evaluation
 - _____ Current Psychological and/or Psychiatric Evaluation
 - _____ Relevant past social, psychological, and/or psychiatric evaluations
 - _____ Medical records/evaluations and developmental history
 - _____ Education/Vocational Evaluations
 - _____ Neurological Assessment (if indicated)
 - _____ Discharge Summaries/Treatment plans from last placement/hospitalization
 - _____ Documentation of physical examination within the past 12 months
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Eligibility Requirements

- _____ Medicaid Recipient / self pay / Others approved on a case by case basis (APS or CSA)
- _____ Active in mental health treatment
- _____ Meets the priority population definition for severely mentally ill
- _____ Impaired role functioning for at least two years

AUTHORIZATION AND RELEASE INFORMATION

I understand that application for rehabilitation services is being made on behalf of me and I agree to this referral for services. I do hereby give permission to Channel Marker, Inc. to provide psychiatric rehabilitation services, including assessment and rehabilitation planning.

Signed: _____ **Date:** _____

Client Signature

Witness/Staff Person _____ **Date:** _____

RELEASE/AUTHORIZATION (effective for 1 year)

If services are terminated or denied, I, _____

Client Name

authorize the release of information pertaining to the denial or termination of services, including the reason for these actions, effective date, and when appropriate, discharge plans. I also understand that this release/authorization is to be used to exchange information and coordinate services between the following agencies/individuals:

Treatment Provider (if different from referring agency, please identify):

Mid-Shore Mental Health Systems (CSA):

APS Healthcare (if client of Public Mental Health System):

Signed: _____ **Date:** _____

Client Signature

Witness/Staff Person: _____ **Date:** _____

REFERRAL FOR PSYCHIATRIC REHABILITATION SERVICES
ADULT SERVICES

I. DEMOGRAPHIC INFORMATION

Name: _____ Age: _____ SSN: _____

Address: _____ Phone: _____

Date of Birth: _____ Gender: M F Race: _____

Marital Status: Single Married Divorced Other: _____

Education/Highest Grade Completed: _____

Employment: _____

Emergency Contact Name: _____ Address: _____

Relationship to client: _____ Phone: _____

Current living arrangement: _____

II. FINANCIAL INFORMATION

Medicaid Number: _____

Other Insurance Type: _____

Current Entitlements/Amount: SSI _____ SSDI _____ Other _____

III. DIAGNOSIS AND MEDICATION

Axis:	Code:	Name of Diagnosis:
Axis I Diagnosis:		
Axis II Diagnosis:		
Axis III Diagnosis:		

Axis IV - Check all that apply:

	None / NA	Mild	Moderate	Severe
Problems in Family Relations:				
Problems in Friendship/Social Relations:				
Legal Issues:				
School/Work Problems:				
Custody/Placement Issues:				
Problems in Living Situation:				
Physical Health:				

Comments:

Axis V Diagnosis - current:	
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Medications (name, amount, frequency): _____

Is the client taking medications as prescribed? Yes No

Has the Primary Care Provider been notified of the psychiatric medication prescribed? Yes No

IV. TREATMENT AND SERVICE HISTORY

Mental Health Treatment Provider/Credentials: _____ Agency/Phone #: _____

Psychiatrist: _____

Number of years of active mental health treatment: _____

Number of Inpatient Admissions in the last 12 months: _____ lifetime: _____

Number of Emergency Room or other crisis episodes in the last 12 months: _____

Reason for ER visit or Inpatient Admission (if known) _____

Number of lifetime homeless episodes: _____

Number of lifetime jail/prison terms: _____

Number of times in Shelter Plus Care: _____

Currently on Probation/Parole/conditional Release: Yes No

Explain:

Risk Factors - history of violence, suicide, aggression, fire setting, etc. (Please describe): _____

Substance Abuse History (Please describe): _____

Medical conditions which would impact participation in services (Please describe): _____

Other Significant medical history (Please describe): _____

V. **REASON FOR REFERRAL** (expectations, strengths and reason for services)

Symptoms and Behavior

Severity: **History Within:**

Symptom/Behavior:	mild	moderate	severe	1 week	3 months	12 months	Over 1 year	Over 10 years
Anxiety/Panic:								
Attachment Problems:								
Binges/Purges:								
Depressed Mood:								
Dissociative Symptoms:								
Grandiose / Hyper Religious:								
Hopeless/Helpless:								
Hyperactive:								
Hypervigilance:								
Impulsive:								
Insomnia:								
Irritable:								
Lying/Malipulative:								
Obsessions/ Compulsions:								
Phobias:								
Property Destruction:								
Psychomotor Agitation:								
Psychomotor Retardation:								
Racing Thoughts:								
Running Away:								
Sexually Inappropriate Behavior:								
Separation Problems:								
Social Withdrawal:								
Stealing:								
Trauma-related Symptoms:								
Truancy:								
Verbal Aggression:								

Comments: