8626 Brooks Drive, Unit 304, Easton, MD 21601
Phone: 410.822.4619 Fax: 410.822.0984
www.channelmarker.org

SERVICES BEING REFERRED TO:

- ☐ Adult PRP (Caroline County, Dorchester County, Talbot County)
- ☐ Youth PRP (Caroline County, Dorchester County)
- ☐ Transitional Age Youth PRP (Talbot County)
- ☐ Supported Employment (Caroline County, Dorchester County, Talbot County)
- ☐ Adult Residential (Contact Mid Shore Mental Health Systems 410.770.4801 for referral form. All Residential Referrals must go through them)

PLEASE SEND REFERRAL FORM AND ADDITIONAL INFORMATION TO:

☐ Channel Marker, Inc.
Caroline County Program
508 Kerr Avenue
Denton MD 21629
410.479.2318 - phone
410.820.0124 - fax
ATTN: County Director

☐ Channel Marker, Inc.
Dorchester County Program
420 Dorchester Avenue
Cambridge MD 21613
410.228.8330 - phone
410.221.6459 - fax
ATTN: County Director

☐ 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 Value Options authorization to process each referral.

**Please include with the completed referral 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)
- ☐ Documentation of physical examination within the past 12 months
- ☐ Discharge Summaries/Treatment plans from last placement/hospitalization

**Signature of Referring Psychiatrist or Therapist:** ______________________________

**Print Name:** ______________________________ **Title:** ______________________

**Referring Agency: Phone Number:** ____________________ **Phone Number:** ____________________

## AUTHORIZATION AND RELEASE INFORMATION

I, ______________________________ , understand that application for rehabilitation services
Client/Parent or Guardian Printed Name

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. I authorize ______________________________ to release/exchange information to Channel Marker, Inc. for
Referring Agency

the purpose of facilitating the referral process. I understand the information exchanged may include diagnosis, evaluations, and progress reports.

I understand I may revoke this consent by written request to Channel Marker, Inc.

**Signed:** ______________________________ **Date:** ______________
Client/Parent or Guardian Signature

**Witness/Staff:** ______________________________ **Date:** ______________

**I. <u>DEMOGRAPHIC INFORMATION</u>**

**Name:** ______________________________ **Age:** ______ **SSN:** ______________

**Address:** ______________________________ **Phone:** ______________

**Legal Guardian/Relationship to Client (if applicable):** ______________________________

**Primary Caretaker (if applicable):** ______________________________

**Date of Birth:** ______________ **Gender:** ☐ M ☐ F **Race:** ______________

**Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced

**Is this individual a veteran?** ☐ Yes ☐ No **If yes, which war?** ☐ Iraq ☐ Afghanistan ☐ Other

Emergency Contacts: (Two contacts must be completed for ALL Youth Referrals, one contact for Adult Referrals)

1. Emergency Contact Name: ______________________________ Relationship: ______________

Address: ______________________________ Phone: ______________

2. Emergency Contact Name: ______________________________ Relationship: ______________

Address: ______________________________ Phone: ______________

Medical Physician: ______________________________ Phone: ______________

Address: ______________________________ Phone: ______________

Psychiatric Physician: ______________________ Phone: ____________

Address: ______________________ Phone: ____________

Primary Therapist/Credentials: ______________________ Phone: ____________

Address: ______________________ Phone: ____________

## II. FINANCIAL INFORMATION:

Medicaid Number: ______________________ Effective Date: ____________

Other Insurance Type: ______________________

**Current Entitlements/Amount:**

☐SSI Amount: __________ ☐Other: __________ Amount: __________

☐Other: __________ Amount: __________ ☐Other: __________ Amount: __________

☐Employed: Employer: ______________________

Job Title: ______________________ Wages: _____/_____

## III. DIAGNOSIS AND MEDICATION

| | Code | Name of Diagnosis |
|---|---|---|
| **Axis I:** | | |
| | | |
| | | |
| **Axis II:** | | |
| | | |
| | | |
| **Axis III:** | | |
| | | |
| | | |

**Axis IV: Check Issue Areas:**

☐None ☐Unknown ☐Educational ☐Financial ☐Housing ☐Occupational ☐Primary Support
☐Social Environment Access to Health Care ☐Other Psychosocial and Environmental ☐Interaction with Legal System/Crime

**Axis V:** Current GAF: __________ Date or Age of Onset of Disability: __________

Medications (name, dosage, monitoring needs):

______________________

______________________

Is the client taking medications as prescribed? ☐Yes ☐No Date of last therapy session: __________

## IV. EDUCATION/EMPLOYMENT

School Name/Highest Grade Completed: ______________________

Diploma: ☐Yes ☐No Certificate of Attendance: ☐Yes ☐No

If currently enrolled in school; Current School Status/Grade: ______________________

Additional Education/Training: ______________________

Work History (positions, dates volunteer or paid):

______________________

______________________

## V. REASON FOR REFERRAL

What are the goals for PRP/Why is the client being referred?

List client's strengths and areas of interest:

List client's areas of needed improvement:

## VI. TREATMENT AND SERVICE HISTORY

History of psychiatric hospitalizations (include dates, hospital, reason, length of stay)

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

Number of Inpatient Admissions in the last 12 months: ____________ Lifetime Hospitalizations: ____________

Reason for ER visit or Inpatient Admission (if known): ____________

Describe behaviors and/or symptoms which indicate decompensation: ____________

Describe history of criminal records: ☐ N/A

Currently on Probation/Parole/Conditions of Release or involved with DJS: ☐ Yes ☐ No

If yes, explain charges/convictions:

Is there a Court Order for this client to attend PRP: ☐ Yes ☐ No

If yes, explain and attach a copy of the order:

Describe Substance Abuse History: ☐ N/A

Describe Medical Conditions that could impact participation/significant medical history, including known allergies:

______________________________________________________________________________

______________________________________________________________________________

**VII. RISK BEHAVIOR CHECKLIST**

If behaviors have occurred within the last 30 days, provide additional information in the comment section including date of last occurrence.

| Behavior/Problem | Current (30 days) | Within Last 12 Months | Over 1 year |
|---|---|---|---|
| Suicidal/Homicidal Threat/Attempt<br>Comment: | ☐ | ☐ | ☐ |
| Self Injurious Behaviors<br>Comment: | ☐ | ☐ | ☐ |
| Possession/Use of Weapons<br>Comment: | ☐ | ☐ | ☐ |
| Fire Setting<br>Comment: | ☐ | ☐ | ☐ |
| Chronic Anger/Aggression (physical, verbal, destruction of property, etc.)<br>Comment: | ☐ | ☐ | ☐ |
| Trauma Related Symptoms<br>Comment: | ☐ | ☐ | ☐ |
| Sexually Inappropriate Behaviors (perpetrator, promiscuous)<br>Comment: | ☐ | ☐ | ☐ |
| Social Interpersonal Conflicts<br>Comment: | ☐ | ☐ | ☐ |
| Family Problems/Peer Conflicts<br>Comment: | ☐ | ☐ | ☐ |
| Coping With Daily Roles & Activities<br>Comment: | ☐ | ☐ | ☐ |
| Learning Difficulties/School or Vocational Problems<br>Comment: | ☐ | ☐ | ☐ |
| Runaway Behavior<br>Comment: | ☐ | ☐ | ☐ |
| Other Behaviors<br>Please describe: | ☐ | ☐ | ☐ |