K&I Healthcare Services
Maryland's Leading Providers for Outpatient Mental Health & Recovery

Referral Form

If possible, please forward Psychiatric Background Information with Referral.

Date Referral Received: _____ Date Completed: _____ Staff Assigned: _____

SEP Start Date: _____ PRP Start Date: _____

Client Last Name: _____ First: _____ Social Security #: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Email Address: _____

Sex: ☐ 1. Male ☐ 2. Female

Race: ☐ 1. American Indian ☐ 2. Asian ☐ 3. African American ☐ 4. White
☐ 5. Other: _____

Hispanic Origin: ☐ 1. Yes ☐ 2. No

Veteran Status: ☐ 1. Yes ☐ 2. No

Residential: ☐ 1. Private ☐ 2. Parent/Guardian ☐ 3. Other Relative ☐ 4. Other Non-Institutional
☐ 5. Other Institutional ☐ Other: _____

Living Arrangement: ☐ 1. Lives Alone ☐ 2. Lives with relatives ☐ 3. Lives with non-related persons

Education: ☐ High School (Grade Completed ___) ☐ High School Grad/GED ☐ Some College
☐ College Graduate ☐ Other: _____

Student: ☐ Full-time ☐ Part-time ☐ Undergraduate

Medical Assistance #: _____ Medicare #: _____ ☐ A or ☐ B

Referral Source: _____

Address: _____ Phone #: _____

Being referred for: ☐ PRP ☐ Supported Employment ☐ Human Service Training
☐ Job Coaching Only ☐ JDPR

Presenting Problems (Identify by number): Primary _____ Secondary _____ Tertiary _____

☐ 1. Marital/Family
☐ 2. Social/Interpersonal
☐ 3. Coping with ADL
☐ 4. Medical/Somatic
☐ 5. Depression
☐ 6. Suicidal/Self Injury
☐ 7. Alcohol Abuse
☐ 8. Drug Abuse
☐ 9. Criminal/Delinquent
☐ 10. Eating Disorder
☐ 11. Psychotic Symptoms
☐ 12. Assault/Abuse Victim
☐ 13. Runaway Behavior
☐ 14. School Program
☐ 15. Violent/Aggressive Behavior
☐ 16. Other: _____

Referred From:

☐ 1. Self
☐ 2. State Psych Hospital
☐ 3. Private Psychiatrist
☐ 4. Other: _____
☐ 5. Family/Friends
☐ 6. Shelter/Homeless
☐ 7. Private MH Practitioner
☐ 8. School System
☐ 9. Community MH Center
☐ 10. Other OP Psych Service
☐ 11. Other OP Psych Servic

Most Recent Hospitalization: From _____ To _____ Name of Hospital: _____

Hospital Address: _____

City: _____ County: _____ State: _____ Zip: _____

Number of: Private Hospitalizations: _____ State Hospitalizations: _____ General Hospitalizations: _____

TOTAL NUMBER OF HOSPITALIZATIONS: _____

Psychiatric Evaluations: Diagnosis - **MUST** show DSM-V Code(s)

Axis I: _____ _____ Primary
_____ _____
_____ _____

Axis II: _____ _____ Primary
_____ _____
_____ _____

Axis III: _____ _____ Primary
_____ _____
_____ _____

Axis IV: _____

Axis V: Current GAF: _____

Problem with Law: ☐ Yes ☐ No
Problem with Alcohol: ☐ Yes ☐ No
Problem with Drugs: ☐ Yes ☐ No
History of Violent Behavior: ☐ Yes ☐ No

Payment Source: ☐ 1. Personal Resources ☐ 4. Medicare ☐ 5. Medical Assistance

Family Size: _____ Number of Dependent Children: _____

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Calculation of Monthly Income:

SSI: $_____
SSDI: $_____
AGDC: $_____
VA: $_____
PAA: $_____
Other Unearned: $_____
Salary/Earned: $_____
Other: $_____
MONTHLY INCOME: $_____

Emergency Contact Name: _____ Relationship: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Status of Benefits:

- ☐ SSI
- ☐ SSDI
- ☐ Medicaid
- ☐ Medicare
- ☐ Pharmacy Assistance
- ☐ Private Insurance: _____
- ☐ Food Stamps
- ☐ HUD Section 8
- ☐ Federal Food Program
- ☐ PASS
- ☐ IRWE

Therapist: _____ Phone #: _____

Address: _____

Psychiatrist: _____ Phone #: _____

Address: _____

Family Doctor: _____ Phone #: _____

Address: _____

Currently being treated: ☐ No ☐ Yes – For what? _____

Medication: _____

DORS Counselor: _____ Phone #: _____

Address: _____

Case Manager: _____ Phone #: _____

Address: _____

Psychiatric Medications:

_____

_____

_____

_____

_____