INSIGHTFUL THERAPEUTIC SERVICES OUTPATIENT MENTAL HEALTH CLINIC REFERRAL

COMPLETE FOR PRP SERVICES REQUESTS: ____ **DATE OF PRP SERVICES REQUEST:** _____

Diagnosis: please indicate current DSM diagnoses. **(MUST HAVE ICD-10 CODE)**

***ADULTS* MUST HAVE ONE OF THE FOLLOWING DIAGOSIS FOR PRP ELIGIBILITY CONVERTED TO ICD 10**

295.90/F20.9Schizophrenia	296.43/F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
295.40/F20.81Schizophreniform Disorder	296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic Psychotic Features
295.70/F25.0Schizoaffective Disorder, Bipolar Type	296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
295.70/F25.1Schizoaffective Disorder, Depressive Type	296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
298.8/ F28 Other Specified Schizophrenia Spectrum and Other Psychotic D/O	296.40/F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
297.1/F22 Delusional Disorder	296.7/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
296.33/F33.2Major Depressive Disorder, Recurrent Episode, Severe	296.80/F31.9 Unspecified Bipolar and Related Disorder
296.34/F33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features	296.89/F31.81 Bipolar II Disorder
301.22/F21 Schizotypal Personality Disorder	301.83F60.3 Borderline Personality Disorder

ICD CODE I:

ICD 10 CODE:

ICD 10 CODE:

Axis Code:

Axis Code:

Diagnosis given by:

Will submit a copy of Assessment: Yes_____ No_____

Rehabilitation Services Needed:

☐ Activities of Daily Living ☐ Safety to Self/Others ☐ Vocational Skills
☐ Anger/Temper/Conflict Resolution ☐ School Performance ☐ Leisure Skills
☐ Assertiveness/Self-esteem ☐ Sexual Issues ☐ Work/Job Performance
☐ Community Activity ☐ Social Skills/Peer Interaction ☐ Legal Issues (# of arrests?)
☐ Family/Natural Supports ☐ Substance Abuse Issues ☐ Money Management
☐ Finances ☐ Coping Skills ☐ Dietary/Food Preparation
☐ Home/Housing ☐ Trauma ☐ Crisis Management Skills
☐ Self Care Skills ☐ Medication Compliance Skills ☐ Physical Health

History of Problems and Rehabilitation Needs: i.e. BE SPECIFIC AND DESCRIPTIVE ABOUT NEEDS (school suspensions, housing, employment, hospitalizations, runaways within the last 30 days, physical assault, substance abuse, disability needs)

_____

_____

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_____

Current Treatment

1. **Therapist Name and Phone Number:** _____
2. **Psychiatrist Name and Phone Number:** _____

Office Use Only

Insurance Authorization Number_____ Number of Auth. Visits:_____
Dates of Authorization From: _____ To: _____
Scheduled Diagnostic Interview ☐ Yes ☐ No Date: _____ Therapist: _____
Immunization Record Request ☐ Yes ☐ No Date: _____
Date Assigned/Comments:_____