Garrett County Lighthouse, Inc.
P.O. Box 116
Oakland, MD 21550
Phone: (301) 334-9126 – Fax (301) 334-8894
www.garrettcountylighthouse.org

PHYSICIAN/MENTAL HEALTH PROFESSIONAL

REFERRAL FOR PRP SERVICES

Date: ________________

Name: _______________________________ Date of Birth: ____________________________

Address: ____

Birthplace: ______________________________ Telephone No.: _________________________

Race: ____________ Sex: M______ F_______ O _______ Pronouns: ____________________

Social Security No.: __________________________ Marital Status: ______________________

Transportation: _________________________ Highest Level of Education: ________________

Medical Assistance Number: ____

Medicare Number: ____

Medical Insurance: _________________________ Policy Number: ______________________

Psychiatric Diagnosis: (PLEASE CHECK AT LEAST ONE)

□ **F20.9** Schizophrenia □ **F20.81** Schizophreniform Disorder □ **F22** Delusional Disorder

□ **F25.0** Schizoaffective Disorder, Bipolar Type □ **F25.1** Schizoaffective Disorder, Depressive Type

□ **F28** Other Specifies Schizophrenia Spectrum and Other Psychotic Disorder

□ **F29** Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

□ **F33.2** Major Depressive Disorder, Recurrent Episode, Severe

□ **F33.3** Major Depressive Disorder, Recurrent Episode, With Psychotic Features

□ **F31.13** Bipolar I Disorder, Current or Most Recent Episode Manic, Severe

□ **F31.2** Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features

□ **F31.4** Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe

□ **F31.5** Bipolar I Disorder, Most Recent Episode Depressed, with Psychotic Features

□ **F31.0** Bipolar I Disorder, Current or Most Recent Episode Hypomanic

□ **F31.9** Bipolar I Disorder, Current or Most Recent Episode Unspecified

□ **F31.9** Unspecified Bipolar and Related Disorder

□ **F31.81** Bipolar II Disorder □ **F60.3** Borderline Personality Disorder

Risk Assessment:

Suicidality ______Ideation _______ Plan________ Prior Attempts (If Known)___________

Other risk Behavior ____

Substance Abuse ____

Psychiatric Hospitalizations ____

____

Psychiatrist ______________________________ Therapist _______________________________

Medications Dosage Prescribed By

____

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____

Medical Condition/Limitations/Allergies ____

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Date of Last Physical ___________________________ Physician __________________________

Others involved in Treatment/Rehabilitation (i.e., AA, NA, Parole/Probation/Addiction Services)

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____

Recommended Service Needs ____

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____

Physician's/Mental Professional's Signature: ____

Print Physician's/Mental Health Professional's Name: _____________________________________

Date: ________________________________

IF LM or LG list supervisor's name and credentials: ______________________________________

Applicant's Signature: ____

(I wish to be considered for Mental Health Services at Garrett County Lighthouse, Inc. and give permission for a Physician's/Mental Health Professional's Referral.)

Date of Admission to Garrett County Lighthouse, Inc. ___________________________________