LIFTING STIGMAS
CHANGING LIVES
OUTPATIENT MENTAL HEALTH CLINIC • COMMUNITY OUTREACH ORGANIZATION

Please fax to 410-665-2632 or email to referrals@lscl.org

Consumer Name:	**D.O.B:**	
Guardian Name: ______________________________ **Does the Parent/Guardian have legal custody (if minor)? Yes/ No**		
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell #**	
Medical Assistance/Medicaid #:		
Is the individual eligible for full funding for Developmental Disabilities Administration services? Yes No		
Have family or peer supports been successful in supporting this youth? Yes No		
Is the primary reason for the youth's impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder Yes No		

ICD-10 Primary Diagnosis Code	
Diagnosing Clinician and Title	
Clinician Agency	
Current frequency of treatment provided to this individual At least 1x/week At least 1x/2 weeks At least 1x/month At least 1x/3months At least 1x/6months	
How long has youth been engaged in active, documented outpatient treatment? Less than one month One visit in the last three months Two or more visits in the last three months	
Is the youth transitioning from an inpatient, day hospital or residential setting to the community setting? Yes No	
Does the youth have a Target Case Management referral or authorization? Yes No	
Has medication been considered for this youth? Not considered Considered and Ruled Out Initiated and Withdrawn Ongoing Other Comments:	

REFERRAL SOURCE

Agency Name:	Contact Person Name:
Address:	
Phone #:	Fax #:
Email Address:	

Criteria for admission (CHECK ALL THAT APPLY AND COMMENT WHERE CHECKED)	
	A clear, current threat to the individual's ability to be maintained in his/her customary setting
Provide of evidence of clear, current threat to the youth's ability to be maintained in their customary setting:	
	An emerging/pending risk to the safety of the individual or others
Provide evidence of emerging risk to the safety of the youth or others:	
	Significant psychological or social impairments such as inappropriate social behaviors causing serious problems with peer relationships and/or family members
Provide evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members:	
What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments:	
How will PRP serve to help this youth get to age appropriate development, more independent functioning and independent living skills:	

Licensed Provider Completing this Application:

Print Name: _ ___________________________________ Signature_______________________________ Date_____________