LITTLE LOVE NOTES, LLC
PSYCHIATRIC REHABILITATION PROGRAM

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Psychiatric Rehabilitation Program Referral Form

Date: ____________________ Referring Agency: ____________________
Therapist Name: ____________________ Number: ____________________
Email: ____________________ Fax: ____________________

Consumer Name: ____________________ DOB: ____________________ Gender: M F
MA#: ____________________ SS#: ____________________ Race: ____________________
Address: ____________________ Phone Number: ____________________
School Name: ____________________ Grade: ____________________
Primary Care Physician: ____________________ Phone: ____________________

If a minor:
Legal Guardian: ____________________ Relationship to Minor: ____________________

Legal Guardian Address: ____________________ Zip: ____________________

Rehabilitation Services Needed:

Activities of Daily Living Coping Skills Trauma Self-Care

Anger/Temper/Conflict Resolution Medication Compliance Family and Natural Support

Assertiveness/Self-Esteem Safety to Self/Others Social Skills/Peer Interaction

Crisis Management Skills Physical Health Substance Abuse Issues

Legal Issues Community Activity Sexual Issues

History of Problems: ____________________

Current Diagnosis: ____________________ **Date of Diagnosis:** ____________________

Somatic Health Concerns? Yes No **Currently taking medication?** Yes No

Collaboration Agreement

I, ____________________ (Therapist Name and Title), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Signature: ____________________ **Date:** ____________________