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#: ______________________ 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
Anger/Temper/Conflict Resolution
Medication Compliance
Self-Care
Assertiveness/Self-Esteem
Safety to Self/Others
Family and Natural Support
Crisis Management Skills
Physical Health
Social Skills/Peer Interaction
Legal Issues
Community Activity
Substance Abuse Issues
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:** ______________