LITTLE LOVE NOTES, LLC
PSYCHIATRIC REHABILITATION PROGRAM

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Psychiatric Rehabilitation Program Referral Form

Date: _____ Referring Agency: _____

Licensed MHP 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
- ☐ Anger/Temper/Conflict Resolution
- ☐ Assertiveness/Self-Esteem
- ☐ Crisis Management Skills
- ☐ Legal Issues
- ☐ Coping Skills
- ☐ Medication Compliance
- ☐ Safety to Self/Others
- ☐ Physical Health
- ☐ Community Activity
- ☐ Trauma
- ☐ Self-Care
- ☐ Family and Natural Support
- ☐ Social Skills/Peer Interaction
- ☐ 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, _____ (Licensed MH Professional 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:** _____

Referrals must be from a mental health professional which includes:
Licensed MH Professionals, including Psychiatrists, CRNP-PMH, Psychologists, LCSW-C, LCPC, APRN-PMH, LCMFT, LCADC, LCPAT, LGMFT, LGADC, and LGPAT.
RN-C, CAC-AD, and CSC-AD are not eligible to make referrals.