

**Little Love Notes, LLC**  
**This is a Referral for Psychiatric Rehabilitation Program Services (PRP)**

Client Name: \_\_\_\_\_ MA#: \_\_\_\_\_ DOB: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

If client doesn't have Medical Assistance: SS# \_\_\_\_\_ (uninsured span criteria must be met to qualify for services without MA)

I am referring the patient for the following services:  PRP Onsite/Offsite  PRP Blended/Telehealth

Please Note: This is a two-page form. This form must be filled out in its entirety in order to allow for medical necessity and authorization for adult services. For minors, please input ICD 10 code in section 4. "Additional Clinical Information" below.

**Category A Diagnosis-** Adults must meet either criteria 1 or 2 under "Additional Service Criteria Requirements" listed below. **Please do not add diagnoses to this form.**

- |  |  |
|--|--|
| <input type="checkbox"/> F20.81 Schizophreniform Disorder  | <input type="checkbox"/> F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder |
| <input type="checkbox"/> F20.9 Schizophrenia   | <input type="checkbox"/> F31.2 Bipolar I Disorder, Current or MRE Manic, /w Psychotic Ft     |
| <input type="checkbox"/> F22 Delusional Disorder   | <input type="checkbox"/> F31.5 Bipolar I disorder, Current or MRE Depressed, /w Psychotic Ft |
| <input type="checkbox"/> F25.0 Schizoaffective Disorder, Bipolar Type                            | <input type="checkbox"/> F33.3 MDD, Recurrent Episode, /w Psychotic Features                 |
| <input type="checkbox"/> F25.1 Schizoaffective Disorder, Depressive Type                         |  |
| <input type="checkbox"/> F28 Other Specified Schizophrenia Spectrum and other Psychotic Disorder |  |

**Category B Diagnosis-** Must meet criteria #2 under "Additional Service Criteria Requirements" listed below.

- |   |   |
|---|---|
| <input type="checkbox"/> F31 Bipolar I Disorder, Current or MRE Hypomanic           | <input type="checkbox"/> F31.9 Bipolar Disorder, Current or MRE Unspecified         |
| <input type="checkbox"/> F31.13 Bipolar I Disorder, Current or MRE Manic, Severe    | o Current or MRE Hypomanic, Unspecified   |
| <input type="checkbox"/> F31.4 Bipolar I Disorder, Current or MRE Depressed, Severe | o Unspecified Bipolar and Related Disorder  |
| <input type="checkbox"/> F31.81 Bipolar II Disorder, Unspecified                    | <input type="checkbox"/> F33.2 Major Depressive Disorder, Recurrent Episode, Severe |
|   | <input type="checkbox"/> F60.3 Borderline Personality Disorder                      |

**Additional Service Criteria Requirements-**

1.  The individual is enrolled in SSI or SSDI
2.  The referred individual demonstrates impaired functioning for at least two years as evidenced by at least 3 of the following criteria on a continuing or intermittent basis. Please include specifics-
  - Marked inability to establish or maintain independent competitive employment**  
\_\_\_\_\_  
\_\_\_\_\_
  - Marked inability to perform instrumental activities of daily living (Shopping, meal prep, household chores, med management, transportation, money management)**  
\_\_\_\_\_  
\_\_\_\_\_
  - Marked inability to establish or maintain personal support system**  
\_\_\_\_\_  
\_\_\_\_\_
  - Marked or frequent deficiencies of concentration, persistence, or pace**  
\_\_\_\_\_  
\_\_\_\_\_
  - Marked inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, personal safety)**  
\_\_\_\_\_  
\_\_\_\_\_
  - Marked deficiencies in self-direction**  
\_\_\_\_\_  
\_\_\_\_\_
  - Marked inability to procure financial assistance to support community living**  
\_\_\_\_\_  
\_\_\_\_\_
3.  Individual doesn't have two years of impaired functioning as required for a category B diagnosis, but they have a new onset category A diagnosis and PRP services are the most effective means to diminish risk.

**4. Additional Clinical information**

Primary Medical diagnoses:

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Social Elements Impacting Diagnosis

- |                                      |  |   |   |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> None        | <input type="checkbox"/> Access to Health Care | <input type="checkbox"/> Housing Problems           | <input type="checkbox"/> Social Environment |
| <input type="checkbox"/> Educational | <input type="checkbox"/> Legal System/Crime    | <input type="checkbox"/> Occupational               | <input type="checkbox"/> Homelessness       |
| <input type="checkbox"/> Financial   | <input type="checkbox"/> Primary Support       | <input type="checkbox"/> Other Psychosocial/Enviro. | <input type="checkbox"/> Unknown            |

Current medications:

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Is the individual med compliant: yes no

Present Symptoms: Please include hx of SI and HI

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Criminal Hx: yes no

Please provide brief reason for referral:

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**Most recent Psychiatric Hospitalization** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_  
Referring Mental Health Professional Signature and Credentials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Referring Professionals Name

\_\_\_\_\_  
Location

\_\_\_\_\_  
Referring Professionals Phone number

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Treating Psychiatrist      Phone

\_\_\_\_\_  
Treating Therapist      Phone

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