ARCHWAY STATION, INC.

408 N. CENTRE STREET • CUMBERLAND, MD 21502

REFERRAL for CHILD, ADOLESCENT & YOUNG ADULT PSYCHIATRIC REHABILITATION SERVICES

FOR INTERNAL USE ONLY:	
Agency Received on:	____/____/____
Received by:	_____ ____/____/____
Screened by:	_____ ____/____/____

Child's Full Name: _____
First Middle Last

Guardian's Name: _____
First Middle Last

Relationship to Child: _____ Are you the child's legal guardian: [ ] Yes [ ] No

Telephone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Cell Other

Address: _____
Street City St Zip

DOB: _____/_____/_____ Age: _____ SS#: _____-_____-_____ [ ] Male [ ] Female

Please provide the name and telephone number of a person we can contact in case there is difficulty reaching the parent/guardian of the person being referred for services.

_____ (_____) _____-_____ _____
Name Telephone # Relationship

Do you have a relative that is currently employed by Archway Station: [ ] Yes [ ] No

If yes, please provide person's name: _____

Referral Source: *Must be referred by a Licensed Mental Health Professional*

_____ _____ (_____) _____-_____ _____
Name License/Credentials Telephone # Agency

Eligibility Review: *In order to be eligible for Archway services, the child must: Have a DSM-5 Priority Population Diagnosis which causes severe problems in the home, school and/or community; Have active Maryland Medical Assistance; Behavior that is stable enough that he/she will benefit from PRP services and, based on the knowledge at hand, is not likely to hurt self or others and; Treatment's written documentation that, due to a severe functional impairment in at least one life domain, the current level of outpatient treatment is not sufficient to prevent further deterioration or an out-of-home placement.*

Eligibility: *Please verify that the child meets the following criteria by placing a check mark and attaching clinical documentation to support (the list of required clinical documentation is listed on the page 2 of this referral).*

[ ] The child has a DSM-5 Priority Population Diagnosis which causes severe problems in the home, school, and/or community.

[ ] The child's behavior is stable enough that he/she will benefit from PRP services and, based on the knowledge at hand, is not likely to hurt self or others

[ ] Treatment's written documentation that, due to a severe functional impairment in at least one life domain, the current level of outpatient treatment is not sufficient to prevent further deterioration or an out-of-home placement.

Medical Assistance:

MA#: _____

FOR INTERNAL USE ONLY - MA Eligibility & Verification
Date Verified: _____/_____/_____ Verified By: _____
Eligibility: _____
Confirmation #: _____
Results of VO Check: _____

Diagnosis:

		ICD-9	ICD-10
Primary Diagnosis:	_____	_____	_____
Secondary Diagnosis:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Medical Diagnosis: _____

_____

Other Conditions that may be a Focus of Clinical Attention: _____

_____

Clinical Information: *(needed to request authorization for services)*

Required - Most recent: *(check off attachments included)*
- [ ] Psychiatric/Psychosocial Evaluation
- [ ] Individual Treatment Plan
- [ ] Progress notes (2 to 3 months of recent notes)

Also, if available: *(check off attachments included)*
- [ ] Discharge Plan (if person is leaving a hospital)
- [ ] Current physical exam results
- [ ] Any other evaluations or information that help describe the person's status/needs.

Presenting Problem:

_____

_____

_____

_____

Medications Prescribed:

[ ] List attached or [ ] Written below

_____

_____

Substance Use Information:

Substance Use History (*Include details of substance used (incl. alcohol), dates used, frequency, amount and how used (smoked, IV, etc.)*

_____

_____

Treatment History for Substance Use Disorders *(Include detox, inpatient & outpatient services as well as dates of treatment)*

_____

_____

Psychiatric Hospitalizations:

Most Recent Psych Admission: ____/____/____ Reason:_____

Total # of Psych Admissions: _____ Summary (include hospital name & dates):_____

_____

Legal Information:

_____

_____

_____

_____

Risk Assessment Information:

	Never	Past Week-Month	Past Month-Year	Past 2+ Years	Please provide Specific Details
Suicide Attempts:	[ ]	[ ]	[ ]	[ ]	
Suicidal Ideations:	[ ]	[ ]	[ ]	[ ]	
Aggressive Behavior/Violence:	[ ]	[ ]	[ ]	[ ]	
Fire Setting/Arson:	[ ]	[ ]	[ ]	[ ]	
Sexual Behavior(s) that are/were: non-consensual, injurious, high-risk, forcible, Pedophilia, etc.	[ ]	[ ]	[ ]	[ ]	
Self-Injurious/Mutilation (not suicidal):	[ ]	[ ]	[ ]	[ ]	

Signatures:

I understand this application is being sent in order to determine if I am eligible to get rehab services from Archway. This application does not bind me to receive services. I still have the right to change my mind later. I give Archway Station, Inc. permission to communicate with the referral source to discuss and share medical and mental health history and information necessary to my referral. *This referral must be signed by the child's parent/legal guardian.*

Signature of Parent/Guardian: _____ Date: ____/____/____

I recommend this person receive rehabilitation services from Archway (Licensed Mental Health Professional).

Referral Source Signature: _____ Date: ____/____/____

Completed referrals, along with all required attachments, can be submitted via fax or mail. Please send to the attention of 'Intake Coordinator'. Fax to (301) 777-8020 or Mail to Archway Station, Inc., 408 N. Centre St., Cumberland, MD 21502.