PARADISE II ADULT PSYCHIATRIC REHABILITATION PROGRAM
7902 Belair Road Baltimore, MD 21236 (410) 661-4938 O (410) 661-4939 F

REQUEST FOR SERVICES
CONSUMER INFORMATION

Last name: _____
First name: _____
D.O.B. : _____
Social security: _____
MA# : _____
Home phone: _____
Address: _____

DIAGNOSTIC INFORMATION

BEHAVIORAL DIAGNOSIS:

- ☐ F20.81 – Schizophreniform Disorder
- ☐ F20.9 - Schizophrenia
- ☐ F25.0 - Schizoaffective Disorder, Bipolar Type
- ☐ F25.1 Schizoaffective Disorder, Depressive Type
- ☐ F28 Other Specified Schizophrenia Spectrum
- ☐ F28 Other Psychotic Disorder
- ☐ F29 Unspecified Schizophrenia Spectrum
- ☐ F22 Delusional
- ☐ F21 Schizotypal Personality Disorder
- ☐ F60.3 Borderline Personality Disorder
- ☐ F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- ☐ F33.3 Major Depressive Disorder, Recurrent Episode, W/
- ☐ F31.13 Bipolar Disorder, Current Most Recent Episode Manic
- ☐ F31.2 Bipolar Disorder, Current Most Recent Episode Manic W/ Psychotic
- ☐ F31.4 Bipolar Disorder, Current Most Recent Episode, Depressed Severe
- ☐ F31.5 Bipolar Disorder, Current Most Recent Episode, Depressed W/
- ☐ F31.0 Bipolar Disorder, Current Most Recent Episode
- ☐ F31.9 Bipolar Disorder, Current Most Recent Episode
- ☐ F31.9 Unspecified Bipolar and Related Disorder

PRIMARY MEDICAL DIAGNOSIS:

Diagnosis Code		**Description**	

SOCIAL ELEMENTS IMPACTING DIAGNOSIS **(Reason for referral):**

- ☐ **Anger Management** ☐ **Medication Management** ☐ **Housing Issues** ☐ **Legal Issues**
- ☐ **Functional Reading/Math Skills** ☐ **Substance Abuse** ☐ **Alcohol Abuse** ☐ **Peer Relations**
- ☐ **Somatic Issues** ☐ **Suicidal Tendencies** ☐ **Homicidal Tendencies** ☐ **Hostile Aggression**
- ☐ **Authority Problems** ☐ **Inappropriate/Bizarre Behavior** ☐ **Behavioral Issues** ☐ **Grooming/Hygiene**
- ☐ **Criminal Activity** ☐ **Violence** ☐ **Threatening Behavior** ☐ **Depression** ☐ **Isolation**
- ☐ **Delusional** ☐ **Entitlement Issues** ☐ **Auditory/Visual Hallucinations** ☐ **Easily Misled** ☐ **Lying**
- ☐ **Stealing** ☐ **Travel Training Needs** ☐ **Conflict with Family**
- ☐ **Other** _____

FUNCTIONAL ASSESSMENT:

Assessment Measure		**Assessment Score**	

PLEASE FAX BACK: 410-661-4939
Or
Email: prp.paradise@gmail.com

REV. 07/07/2014

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NAME _____

LIST CURRENT MEDICATIONS:

MEDICATION	DOSE	ROUTE	FREQUENCY	REASON
1.				
2.				
3.				
4.				
5.				
OR PLEASE ATTACH A MEDICATION LIST				

PRESENTING PROBLEMS

Describe Risk Behaviors (include symptoms, duration & frequency):

_____

_____

_____

List psychiatric history & hospitalizations (specify dates):

_____

_____

_____

REFERRAL SOURCE

Psychiatrist Name: _____
Psychiatrist Phone# _____
Psychiatrist Fax#: _____
Psychiatrist Address: _____

Therapist Name: _____
Therapist Phone# _____
Therapist Fax#: _____
Therapist Address: _____

Referring Worker Name and Title _____ **Signature** _____ **Date** _____

OFFICE USE:

Date Sent:		**Date Received**	
Initial Assessment date		**Screening assessment date**	

Initial Assessment or Screening was completed within 10 days of referral? ☐ YES ☐ NO

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