ARCHWAY STATION, INC.

408 N. CENTRE STREET • CUMBERLAND, MD 21502

REFERRAL for ADULT PSYCHIATRIC REHABILITATION SERVICES

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

Name: _____ [ ] Male [ ] Female
First Middle Last

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

Address: _____
Street City St Zip

DOB: _____/_____/_____ Age: _____ SS#: _____-_____-_____ Veteran: [ ] Yes [ ] No

Please provide the name and telephone number of a person we can contact in case there is difficulty reaching 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, a person must have a DSM-5 Priority Population Diagnosis, Active Maryland Medical Assistance and at minimum, 3 out of the 5 listed Functional Limitations related to their mental health problem, on a continuing or intermittent basis for at least 2 years.*

Diagnosis:

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

Medical Diagnosis: _____

_____

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

_____

Medical Assistance:

MA#: _____

FOR INTERNAL USE ONLY - MA Eligibility & Verification

Date Verified: _____/_____/_____ Verified By: _____

Eligibility: _____

Confirmation #: _____

Results of VO Check: _____

Functional limitations: *Check all that apply*

[ ] Inability to maintain independent employment
[ ] Social behavior that results in interventions by the MH system
[ ] Inability, due to cognitive disorganization, to procure financial assistance to support living in the community
[ ] Severe inability to establish or maintain personal support system
[ ] Need for assistance with basic living skills

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

_____

_____

Ability to take Medications:

[ ] Medications Not Prescribed [ ] Independently [ ] With Reminders [ ] With Daily Supervision
[ ] Refuses Medications

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:

Currently on Probation/Parole: [ ] Yes [ ] No If yes, Probation End Date: ____/____/____

Probation/Parole Officer: _____ (_____) _____-_____
Name Telephone #

Currently on a Conditional Release Order from the court/judge: [ ] Yes [ ] No

If yes, Conditional Release Order Expiration Date: ____/____/____

Has applicant ever been found NCR (Not Criminally Responsible): [ ] Yes [ ] No

Community Forensic Aftercare Program: *For applicants that have been adjudicated by the Circuit Court as Not Criminally Responsible:*

CFAP Monitor: _____ (_____) _____-_____
Name Telephone #

Required to Register thru the MD Sex Offender Registry: [ ] Yes [ ] No

If yes, specify the level as identified by the MD Sex Offender Registry: [ ] Tier 1 [ ] Tier 2 [ ] Tier 3

Current Charges: _____

_____

Reported Convictions: _____

_____

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.

Applicant's Signature: _____ Date: ____/____/____

I recommend this person receive 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.