

**PSYCHOSOCIAL REHABILITATION
REFERRAL**

CLIENT NAME: _____

AMHD REFERENCE #: _____

CLIENT CASE ID#: _____

DOB _____ **SSN#:** _____

CASE MANAGER: _____

CM CONTACT #: _____

INSURANCE INFO: _____

DIAGNOSIS: AXIS I: _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V _____

OFFICE CLT WILL ATTEND: _____

(AIEA, EWA, WAHIAWA, MAKAHA)

NOTE: Please be sure to attach current MRP, revised to reflect attending PSR program as one of the goals. This would fall under psychosocial category. An example goal is as follows:

CM will submit necessary paperwork for referral to PSR program. Clt will attend the program at least _____ (fill in here a reasonable expectation of how often this client will attend, i.e. 2x/per month, 1x/per week, etc...) Clt will attend program in order to increase healthy life skills and decrease isolation.

Client Signature/Date

CM Signature/Date