Restoring Destiny Mental Health Services Referral Screening Form

Thank you so much for this referral. In order to have services delivered smoothly and efficiently. This referral form needs to be completed in order to determine if this patient is appropriate for outpatient mental health treatment with Restoring Destiny Mental Health Services.

For your convenience, this form can be completed and faxed to Restoring Destiny Mental Health Services at (443)478-4707 or emailed to restoringdestinymentalhealth@gmail.com. If you have any questions, please call us at 443-282-8146 or email us. Please attach a copy of patient's/parents ID and medical assistance card.

Patient's Name & Date of Birth: _____

Current Address: _____

Telephone Number/Email Address: _____

Social Security Number: _____

Medical Assistance Number: _____

Parent/Guardian Name and Contact Info:_____

School Name and Grade:_____

Emergency Contact Name & Relationship:_____

Emergency Telephone Number: _____

Primary Care Provider/Pediatrician and Last Physical: _____

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Previous Mental Health Provider and Last Date of Treatment: _____

Is the patient currently taking psychiatric medications? Is so, name all medications as well as the psychiatrist or CRNP who prescribed them and when was their last visit?

_____

History of Homelessness, Incarceration or Foster Care Placement? Are CPS or APS currently involved with this patient? Is the patient currently enrolled in a case management program? If so, provide specifics.

_____

Has this patient ever been hospitalized for mental health related diagnosis? _____

Is this patient currently on probation or parole? Would therapy be court ordered? _____

Is the patient able to commit to biweekly therapy sessions? _____

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