51 Monroe Street, Suite 1405
Rockville, MD 20850
866.990.2199 phone
301.838.8552 fax
www.recoverycareoptions.com

MARYLAND CHOICES REFERRAL FORM

Services

❑ Traditional

❑ ATD

❑ IFP

Maryland Choices Care Coordinator Information

Name: Work Phone:

Cell Phone: E-mail Address:

Parent/Guardian Information

Parent Name: Date:

Home Address: City, State, Zip:

Home Phone: Work Phone:

Cell Phone: E-mail Address:

Custody: (Dual full/Maternal Joint/Paternal Joint/ Sole Legal/Guardian

Child to Receive Treatment—General Information

Name: Date of Birth: ❑ M ❑ F

School: Grade:

Grade: Counselor: Hair color: Eye color:

Height: Weight: Image/Dress:

Distinguishing Marks: Physical skill level: ❑ Very athletic
❑ Somewhat athletic
❑ Inactive

Has own cell phone: ❑ Yes ❑ No

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Reasons for Referral

Precipitating events:

Substance abuse:

Behavioral:

Violent behavior:

Access to weapons:

Suicidal:
Any attempts?
Self-mutilation:
Smokes: ❏ Yes ❏ No
DJS Involvement: ❏ Yes ❏ No
DSS Involvement: ❏ Yes ❏ No

Medical/Pychiatric Profile

Medical History:
Psychiatric history of counseling
Clinical Assessment (any disorders):
Medications:
Type/How much:
Moods/Behaviors:
Aggressive or Passive
Respectful or Disrespectful
Compliant or Non-compliant
Verbal or Non-verbal
Physically acting out? ❏ Yes ❏ No
How?

Requested Services

❏ Crisis Intervention (5140)
❏ Family Assessment (5161)
❏ Family Therapy (5110)
❏ Group Therapy (5120)
❏ Individual Therapy (5100)
❏ Parenting/Family Skills Training Groups (5528)
❏ Substance Abuse Therapy—Group (5121)
❏ Substance Abuse Therapy—Individual (5101)
❏ Clinical Mentor (5524)
❏ Educational Mentor (5521)
❏ Life Coach/Independent Living Skills Mentor (5526)
❏ Parent & Family Mentor (5522)
❏ Recreational/Social Mentor (5525)
❏ Supported Work Environments (5560)
❏ Team Meeting (5515)
❏ Community Supervision (5530)

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Plan of Care

Goals and Objectives

Additional Notes