

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

SS# \_\_\_\_\_

**Instructions:**

The person named above has been referred to Advocate Support Services, Psychiatric Rehabilitation Program and has expressed a desire to receive these services from Advocate Support Services. We exclusively provide off-site Psychiatric Rehabilitation services to adults in their homes and community, However, one of the requirements of admission to our program is a referral from their psychiatrist. which is why you are receiving this request.

Please call Sandy Ironmonger at 410-353-8934 if you have specific concerns about this individual participating in this program, or need more information about Psychiatric Rehabilitation Services or Advocate Support Services before making a referral determination.

**Please complete your contact information, indicate all Axis I diagnosis (specify the number) and sign this referral form and fax a copy to 800-372-0799.**

**Psychiatrist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

\_\_\_\_\_ **Email:** \_\_\_\_\_

\_\_\_\_\_

**DIAGNOSIS: Axis I:** \_\_\_\_\_

**Axis I:** \_\_\_\_\_

**Axis I:** \_\_\_\_\_

I am referring the above named Client, a patient of mine, to receive Psychiatric Rehabilitation Services from Advocate Support Services. I believe that there is a reasonable expectation that these services will help this patient to improve and/or maintain their independence and current functional level in the community.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_