UNITY FIRST
WELLNESS

1718 Belmont Avenue, Suite D, Windsor Mill, MD 21244
Phone 240.898.2243 | Secure Fax 240.751.1928
care@unityfirstwellness.com | unityfirstwellness.com
*Unity First Primary & Pain Care • Unity First MindCare • Unity First Wellness & Prevention*

# PRP PARTNER REFERRAL TO UNITY FIRST WELLNESS

*For Psychiatric Rehabilitation Programs referring participants for psychiatric, behavioral health, or primary care services*

Fax the completed form and records to 240.751.1928 or call 240.898.2243. Our intake team contacts the patient within 2 business days of a complete referral and confirms receipt with your office.

* Required field. Fields without an asterisk are optional or complete when applicable. Do not include Social Security numbers.

## SECTION A REFERRING PRP PROGRAM

| | | | |
|---|---|---|---|
| **PRP Program Name** * | **Program NPI** | **Referral Date** * | **Program Phone** * |
| **Rehabilitation Specialist or Staff Completing Form** * | **Direct Phone** * | **Secure Fax** * | **Email** |
| **Program Director or Clinical Supervisor** | **Program Address** | | |
| **Preferred Contact** * | ☐ Secure fax ☐ Phone ☐ Secure email | | |

## SECTION B PARTICIPANT INFORMATION

| | | | |
|---|---|---|---|
| **Full Legal Name (Last, First, Middle)** * | **Preferred Name** | **Date of Birth** * | **Phone** * |
| **Street Address, City, State, ZIP** * | | **Email (optional)** | |
| **Maryland Medicaid (MA) Number** * | **HealthChoice MCO** | **Other Insurance and Member ID** | **Preferred Language** * |
| **Parent or Legal Guardian (if applicable) and Phone** | | **Best Days and Times to Reach Participant** | |
| **Visit Preference** * | ☐ In person (Windsor Mill) ☐ Telehealth ☐ Either | | |
| **Supports Needed** | ☐ Interpreter ☐ Transportation assistance ☐ PRP staff to attend first visit ☐ None | | |

## SECTION C SERVICES REQUESTED

**Unity First MindCare** *

☐ Initial psychiatric evaluation ☐ Transfer of psychiatric care ☐ Family therapy
☐ Psychiatric medication management ☐ Individual therapy ☐ Diagnostic clarification

**Unity First Primary & Pain Care**

☐ Establish primary care ☐ Chronic disease management ☐ Medication reconciliation
☐ Annual physical or preventive visit ☐ Chronic pain evaluation ☐ Other medical need:

| | |
|---|---|
| **Priority** * | ☐ Routine ☐ Expedited (explain below) |

**Reason for Referral** * *What the participant needs and why now*

Participants in crisis or at imminent risk should be connected to 988, mobile crisis, 911, or the nearest emergency department. Unity First Wellness is not an emergency service.

## SECTION D CURRENT TREATMENT PICTURE *Share what your program knows; leave blank if unknown*

| | | |
|---|---|---|
| **Current Psychiatric Prescriber** * | ☐ None ☐ Yes, transferring care ☐ Yes, continuing elsewhere | |
| **Current or Most Recent Mental Health Provider and Phone** | | **Date of Last Psychiatric Visit** |
| **Known Diagnoses (as documented by the treating provider)** | | **Current Medications (or attach list)** * |

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| Psychiatric Hospitalizations or ED Visits (last 12 months) | Medication Supply Remaining (days) | Primary Care Provider (if any) |
|---|---|---|
| | | |

| Program Observations (functioning, engagement, IRP goals relevant to this referral) | |
|---|---|
| | |

| Current Safety Concerns * | ☐ None known ☐ Yes (describe in reason for referral) |
|---|---|

## SECTION E CONSENT, RECORDS, AND COORDINATION

| Participant Agrees to Referral * | ☐ Yes ☐ No |
|---|---|
| Release of Information (PRP and Unity First) * | ☐ Signed and attached ☐ Will be signed at intake ☐ Not yet discussed |

**Records Enclosed**

☐ Insurance card (front and back) ☐ Most recent psychiatric evaluation ☐ Recent progress note

☐ Medication list ☐ Individual Rehabilitation Plan (IRP) ☐ Other record:

| Substance Use Records | ☐ None enclosed ☐ Enclosed with Part 2 consent ☐ Enclosed; not Part 2 records |
|---|---|

**Participant choice.** Participants choose their own providers. Unity First Wellness does not require or offer reciprocal referrals, and any future Unity First recommendation about PRP services is based solely on an independent clinical evaluation and the participant's informed choice of programs.

| Referral Source Signature * | Date (MM/DD/YYYY) * | Printed Name and Credentials * |
|---|---|---|
| | | |

| Participant Signature (optional) | Date |
|---|---|
| | |

## FOR UNITY FIRST WELLNESS USE ONLY

| Date Received * | Referral ID * | Insurance Verified (date / staff) * | Assigned Clinician * |
|---|---|---|---|
| | | | |

| Referral Complete | ☐ Yes ☐ No, information requested |
|---|---|

| Patient Contacted (dates / outcome) | Appointment Scheduled (date / clinician) |
|---|---|
| | |

| Referral Source Notified (date) | Declined or Redirected (reason) | Staff Initials * |
|---|---|---|
| | | |

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