Transformation Healthcare INC.

Pre-Authorization Referral Form

326 St. Paul Place Suite 202 Baltimore MD 21202
Office 410-878-1085 I Fax 410-755-7797 | admin@transformationhealthcare.com

Date of Referral: _____

Referring Agency:_____**Phone#:**_____**Contact:** _____

Email of contact: _____

How did you hear about us? _____

Name:_____DOB:_____SS#:_____

Parent/Legal Guardian Name:_____ Gender: M / F / O Marital Status:_____

Address:_____Contact Phone #: _____

Email:_____Emergency Contact: (Name/Phone) _____

Insurance:_____

Medicaid Medicare

MA#_____ Medicare ID: _____

QMB is Medicare - *Medicare ID #'s are 11 digit alpha-numeric*

If Medicare, please complete the following questions below:

Criteria for PRP Uninsured/ State Funded Coverage Questions	Yes	No
Recently Incarcerated?		
Hospitalized for mental health within the last 6 months?		
Placed in a state hospital?		
A RRP (Residential Rehabilitation Service) Bed within the last 6 months?		

Reason for Referral/Presenting Problems (PLEASE BE SPECIFIC): _____

Type of Care (PLEASE CHECK ALL THAT APPLY, if qualified):

_____Psychiatry

_____Medication Management

_____Therapy

_____PRP Services (If qualifying diagnosis)

_____Substance Abuse Recovery Treatment

Highest level of Education: _____

Any arrest in the past 30 days? Y ☐/ N ☐

Currently Employed? Y ☐/ N ☐

Veteran? Y ☐ / N ☐

In Iraq or Afghanistan? Y ☐ / N ☐

Is the client eligible for MTA pass? Y☐ /N ☐

Any restrictions from referring agency (i.e., mobile therapy, on blackout, no telemedicine, etc.)? Y☐ /N☐

If yes, please explain:_____

Have you been in a PRP Program before? Y ☐/ N ☐ If so, what agency?_____

Office Use Only:

Intake date & time_____Therapist assigned_____Completed by: _____