Center for Personal Growth, Inc.
"Dedicated To Improving Your Mental Health"
Telephone: (619) 405-6378 Fax: (619) 528-8054
www.centerforpg.com

Before completing the Skills System Group Referral Form, please complete the inclusion and exclusion criteria listed below:

Inclusion Criteria (If left blank this form will be returned to you):

The client is dually diagnosed (developmental disability and co-occurring psychiatric diagnosis) and be able to provide documentation of these diagnoses.

☐ Yes. Client's psychiatric diagnosis:_____

☐ No. If you believe the client has an undiagnosed psychiatric diagnosis, please describe the client's current symptoms (the reason you are making the referral):

_____

_____

Exclusion Criteria (check all that apply):

The person has a history of being AWOL and this issue is part of the person's current treatment plan/interventions. ☐ Yes ☐ No

The person has a high degree of self injurious behavior management as part of their current treatment plan/interventions. ☐ Yes ☐ No

The person has a high degree of physical or verbal aggression, property destruction, or recent incidents as part of their current treatment plan/interventions. ☐ Yes ☐ No

The person has a seizure disorder not reliably controlled by medication. ☐ Yes ☐ No

The person requires assistance with bathroom use. ☐ Yes ☐ No

The person has a history of fire setting behavior. ☐ Yes ☐ No

The person has a history of inappropriate sexual behavior. ☐ Yes ☐ No

The person has problematic substance abuse. ☐ Yes ☐ No

The person does not use words to communicate and does not have appropriate facilitation available. ☐ Yes ☐ No

If you answered "Yes" to any exclusion criteria, please provide details:

_____

_____

_____

Locations:

Center for Personal Growth, Inc. 4656 30th St. San Diego, Ca. 92116	*San Diego Center for Family Therapy, Inc.* 124 East 30th St., Suite A1 National City, Ca. 91950	*Exodus Recovery, Inc.* 550 West Vista Way, Suite 109 Vista, Ca. 92083

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General Information:

Name: _____

Address: _____Apt:_____

City:_____State:_____Zip Code:_____

Telephone (Check one: ☐ Home ☐Cell):_____

Date of Birth:_____

Type of residence:_____

Email:_____

At which location would you like to receive services? Check all that apply:

☐ San Diego ☐ National City ☐ Vista

Emergency Contact Information:

Name:_____

Relationship to client:_____

Telephone (Day/Evening/Cell):_____

Designated Skills System Support Person (Required/Mandatory):

Part of the requirement for enrolling a client in the Skills System program is that clients have a Designated Support Person. This person should be someone who knows the client well and has frequent and regular contact with the client. This person will be required to accompany the client to and participate in the Skills System Support Person's group once per month on a designated Wednesday night from 6:00 pm to 7:00 pm. Please ensure you have explained the responsibilities of this role to the designated support person and they have agreed to fulfill this role prior to submitting the referral form. **If left blank, the referral will not be processed and this referral form will be returned to the SDRC SC**. Who will be the client's designated support person:

Name: _____ Tel.#:_____ Relationship:_____

Please Note: Participants receiving services at the National City location will be required to attend the monthly Support Person Group meetings at our Normal Heights Location.

Other People who provide support to the client:

Name: _____ Tel.#:_____ Relationship:_____

Name: _____ Tel.#:_____ Relationship:_____

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Legal Representative:

Does the client have a conservator or is the client a minor who needs parental consent to receive therapy services?

☐ Yes If Yes…YOUR CONSERVATOR MUST ATTEND THE INTIAL SCREENING APPT.
☐ No

If Yes, please provide the following information:
Name of conservator or legal representatives: _____

Telephone number of conservator or legal representative: _____

Note to SDRC Service Coordinator:

Thank you for referring this client to the Skills System Group. Please submit two POS' for these services (one for group therapy services and one for individual therapy services – Service code 117: Spec. Therap. Svc.). The initial POS for group therapy services should be submitted for 64 units and have a time frame of one year. The initial POS for individual therapy services should be for 34 units (14 initial units and two estimated additional increments of 10 units each) and should also have a time frame of one year. Please use the date of the referral form as the start date for these POS'. Our vender number with the SDRC is: PQ9550. In addition, please forward the following collateral information:

- Consumer Information Sheet
- Individual Program Plan (IPP)
- Individual Program Plan (IPP) Services and Supports Form
- Client Developmental Evaluation Report (CDER)
- Psychological Report/Evaluation
- Behavior Assessment
- Social Summary/Assessment
- Medical Evaluation

By signing below, I certify that I have submitted the requested POS' for approval and requested collateral information be sent to the Center For Personal Growth.

*SDRC SC Print Name:*_____

*SDRC SC Signature:*_____ *Date:*_____

Tel.#:_____

☐ 4355 Ruffin Road, San Diego, Ca. 92123
☐ 8760 Cuyamaca St, #100, Santee, Ca. 92071
☐ 2727 Hoover Ave, #100, National City, Ca. 92150
☐ 5931 Priestly Drive, Suite 100, Carlsbad, CA 92008

Thank you for completing the Skills System Group Initial Screening Form. Please scan and email this form to BNewcomer@centerforpg.com.

This information will be reviewed by a Skills System staff member who will contact you to discuss the content and/or schedule an initial screening appointment with the client.

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