Maryland Community Criminal Justice Treatment Program (MCCJTP)
Referral Form

Name: _____ **Birth Date:** _____

Address : _____ **Contact #:** _____

Referring Agency: _____ **Referral Date:** _____

Contact Person: _____ **Contact#:** _____

Incarcerated in: ☐ Prison ☐ Detention Center **Date Released:** _____

(In order to qualify for services participants must have been released from incarceration in the last 30 days.)

Diagnosis List – *Must have one or more of following. (Referrals will not be accepted without a diagnosis)*

Schizophrenia: ☐ 295.4/F20.81 ☐ 295.7/F25.0 ☐ 295.7/F25.1 ☐ 295.9/F20.9

Bipolar Disorder: ☐ 296.43/F31.13 ☐ 296.44/F31.2 ☐ 296.53/F31.4 ☐ 296.54/F31.5
☐ 296.40/F31.0 ☐ 296.40/F31.9 ☐ 296.7/F31.9 ☐ 296.80/F31.9 ☐ 296.89/F31.81

Major Depressive Disorder: ☐ 296.23/F32.2 ☐ 296.24/F32.3 ☐ 296.33/F33.2
☐ 296.34/F33.3

Other Psychotic Disorder: ☐ 297.1/F22

Schizotypal and Borderline Personality Disorder: ☐ 301.22/F21 ☐ 301.83/F60.3

Diagnosing Provider: _____ **Date of Diagnosis:** _____

Reason for referral:

_____

_____

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_____

Please fax completed form to Sarah Pinardi at 301-777-5621

MCCJTP Only

Eligible for MCCJTP Services ☐Yes ☐No

Reason if Denied: _____

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