Psychiatric Rehabilitation Referral Form

Phone: 814.688.0053 Fax: 814.726.8426
Email: ccp@beacon-light.org

Person Referred

Name:	Date of Birth:	Date of Referral:
Gender: Male ☐ Female ☐	Social Security #:	Insurance:
Address		Phone:

Referral Source

Name:	Agency/Relationship to Referred:
Phone:	Email:

Reason for Referral: List specific concerns

Please provide information on how the Psych Rehab program may benefit the person being referred in any of the following areas:

Describe any needs around the area of <u>living independently:</u>	
Describe any needs around the area of continuing <u>education:</u>	
Describe any needs around the area of <u>employment:</u>	
Describe any needs around the area of <u>social/relational skills:</u>	
Describe any needs around the area of <u>wellness management:</u>	
Other needs:	

Do you need help with getting to Psych Rehab? *(Med Bus is not available for Psych Rehab services)*

Has Own Transportation ☐ **Uses Public Transportation ☐** **Needs Transportation Assistance ☐**

School Will Transport ☐

Name _____ DOB _____

Medical Necessity

The following section must be completed by a Licensed Practitioner of the Healing Arts*. This term is limited to*

- *Physician (MD)*
- *Physician's Assistant (PA)*
- *Certified Registered Nurse Practitioner (CRNP)*
- *Licensed Clinical Social Worker (LCSW)*
- *Licensed Marriage and Family Therapist*
- *Licensed Professional Counselor*
- *Psychologist*

Admission Criteria Information

	Yes	No
Participant is age **fourteen or older**.	☐	☐
Participant has a documented serious psychiatric disability. ***This term is limited to the following conditions:*** • Schizophrenia • Schizoaffective disorder • Other Specified Schizophrenia Spectrum and Other Psychotic Disorder • Major Depressive Disorder • Bipolar Disorder • Anxiety Disorders • Posttraumatic Stress Disorder • Borderline Personality Disorder **Exception**: An individual who does not have a diagnosis listed above is eligible for PRS if the individual has a written recommendation from an LPHA that includes the following information: (1) Documentation of a diagnosis of a mental, behavioral or emotional disorder that is listed in the current DSM or ICD, which results in a moderate to severe functional impairment in the area of living, learning, working, socializing, or wellness. (2) Documentation that it is anticipated that PRS will help the individual reach the individual's desired goal.	☐	☐
Participant **agrees** to participate in services.	☐	☐
Participant exhibits moderate to severe impairment in **independent living, social, educational, vocational, and/or self-maintenance** functioning. *(Must have some impairment resulting from mental illness to qualify)*	☐	☐

Diagnosis	**ICD 10 Code**
1. _____	ICD 10_____
2. _____	ICD 10_____
3. _____	ICD 10_____
4. _____	ICD 10_____

LPHA's Signature and Credentials:	Date:

For internal use only:

Reviewed By:	Date:	Accepted: ☐ Yes ☐ No