BEACON LIGHT
BEHAVIORAL HEALTH SYSTEM

Psychiatric Rehabilitation Referral Form

Phone: 814.723.1832 Fax: 814.726.8426

Referral Information

Date of Referral:	Referring Agency or Program:
Referral Contact Person:	Phone:

Reason for Referral: List specific concerns

Social Functioning -
Educational Functioning -
Vocational Functioning -
Self Maintenance -
Other -
Services recommended: ☐ Site Based Services

Participant Information

Name:	Date of Birth:	BLBHS ID# if known:
Gender: ☐ Male ☐ Female	Social Security #:	
Address:		
Phone Number:		

Billing Information

Does the participant have Medical Assistance? ☐ Yes ☐ No Card#:

This section to be completed by Licensed Prescriber:
I provide treatment to this individual. It is medically necessary for this individual to participate in Psychiatric rehabilitation services. The individual meets the eligibility requirements listed below.

Admission Criteria Information

	Yes	No
Participant is age **eighteen or older**.	☐	☐
Participant has a documented serious psychiatric disability such as **schizophrenia**, **major mood disorder**, **psychotic disorder**, **schizoaffective disorder**, or **borderline personality disorder**.	☐	☐
Participant **agrees** to participate in services.	☐	☐
Participant exhibits moderate to severe impairment in **social, educational, vocational, and/or self-maintenance** functioning.	☐	☐

Diagnosis—Please include a primary behavioral health diagnosis. Other diagnoses may be included.

Behavioral Health:
Behavioral Health:
Behavioral Health:
Medical Conditions/Physical Health Issues:
Medical Conditions/Physical Health Issues:

Signature and Credentials:	Date:

Reviewed By:	Accepted: ☐ Yes ☐ No