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

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

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

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 **eighteen 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.	☐	☐

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