

**PSYCHIATRIC REHABILITATION REFERRAL FORM
CHESTNUT RIDGE COUNSELING SERVICES, INC.**

Referring Agency:

Phone: 724-437-0729

Name:

Credible ID:

Address:

Phone #:

County: __ Fayette

Type of Residence: Home/apart _____ PCH:

DOB:

Age:

Gender:

Ethnic Origin:

Education: _____ Employment Status / Where:

Marital Status:

SSN:

VBH#

Diagnosis / Problem: 1.

2.

3.

Specify Areas of Impairment Affected for Justification of Services / Diagnosis Exception:

Living:

_____ Financial Management

_____ Housing / Household Maintenance

Education:

_____ Educational Supports

Work:

_____ Vocational Supports

Social:

_____ Exploration of Interpersonal Leisure / recreation

_____ Communication skills

Wellness / Self Maintenance:

_____ Peer / Family Education and Support

_____ Symptom / Illness Management

_____ Basic Self- Care Skills, Activities of Daily Living

My signature on this form indicates my belief that this individual will benefit from his / her involvement with Psychiatric Rehabilitation services.

Healing Arts Professional (MD, DO, Psychiatrist, Psychologist, CRNP, PA)

Printed Name

Date

Credentials

NPI:

MA Promise ID:

Name:
Current Treatment:

Credible ID:

Agency:

Dr: _____ Therapist: _____ N/A _____

BCM: _____ Agency _____

Other Agencies Involved: _____

Supports:

Date of Last Hospitalization:
Any Significant Medical Conditions:
Medications
Other limitations or challenges:

Specific Reason for Referral:

Rehabilitation Domains: Check One Rehab Goal Area and specify desired client goal for that area

 1. Educational _____

 2. Vocational _____

 3. Social _____

 4. Living Environment :

 5. Self-Maintenance: Managing Illness:

Name:

Credible ID:

Specific skill development needed to accomplish above goal _____

_____The individual is interested in and chooses to participate in MPR services at this time.

Consumer Signature: _____
OR

The individual is interested to learn more about MPR services and may potentially choose services.

Referring Agent:

Name: _____

Date:

Agency: CRCSI

Phone: 724-437-0729 Email: _____

<i>For PR staff use only</i>	
<input type="checkbox"/>	Referral accepted by: _____ PR Practitioner Date
<input type="checkbox"/>	Referral not accepted because:
<input type="checkbox"/>	Referral source notified on: _____ (date)