PSYCHIATRIC REHABILITATION – Referral Form
CHESTNUT RIDGE COUNSELING SERVICES, INC.

Client Name _____ **Age** _____ **DOB** _____

Address Street _____

City _____ **State** ____ **County** _____ *(Only Fayette County Residents Eligible)*

Home Phone _____ **Cell Phone** _____ **Alternate Phone** _____

Primary DSM Diagnosis & Code:

_____

Plus Functional Deficit Area(s) Checked Below

☐	**Ages 14-17**
☐	**For Ages 18+ -** Schizophrenia, Major mood disorders, Psychotic disorder, Schizoaffective disorder, or Borderline personality disorder qualify for services. **<u>For any other diagnoses</u>,** an attached exception letter should be completed and signed by the LPHA to necessitate Psychiatric Rehabilitation Services due to a functional impairment in the area(s) marked below.

Check 1 or More Below Functional Areas Needing Improvement

☐	**Living** - *Independent Living Skills, Meal Preparation, Cost effective Shopping, Money Management, Using public transportation, Linking to Resources and Community Services, housing assistance*
☐	**Educational/Vocational/Work/Volunteering**
☐	**Social** – *Development of healthy Relationships, development of natural supports, friendship development, development and linkage with positive leisure/recreation/hobbies, Communication Skills*
☐	**Wellness/Self Maintenance** - *MH Illness education, coping skills, self-advocacy, healthy lifestyle, family relationships, hobbies, follow thru with preventive and ongoing physical health services, quality of life satisfaction exploration and improvement, elimination of barriers, turning weaknesses into strengths*

If applicable, any additional Pertinent Information

I am Recommending/Ordering Psychiatric Rehabilitation Services based on the individual's Mental Health Diagnosis and the above listed functional improvements needs.

Signature of Ordering/Referring Licensed Practitioner of the Health Arts _____ **Date** _____

Printed Name of Licensed Practitioner of the Health Arts _____

☐ **MD** ☐ **DO** ☐ **CRNP**
☐ **PA** ☐ **LCSW** ☐ **LPC**

Licensed Practitioner of the Healing Arts

***Signing LPHA must have a Medicaid Promise ID # under their own name**

NPI # _____ **PA Promise ID** _____

If available, Alternate Contact for Referring Practitioner/Organization

Alternate Staff Name _____

Name of Practice/Organization _____

Direct Phone / Ext _____

If Known:

Type of Insurance(s):

☐ Beacon Health Options Medicaid
☐ Commercial Ins
☐ Medicare
☐ Non-managed Medicaid
☐ Commercially Managed Medicare
☐ No Current Insurance Coverage

Name of Client's Primary Insurance _____

Insurance ID # _____

Name of Client's Secondary Insurance _____

Insurance ID # _____

Fax Completed & Signed Form To: CRCSI – MPR at (724) 437-3221

Any ? Call (724) 437-0729 Ext 6570

Clients are eligible to continue in Outpatient and Community Based Services when while enrolled in Psychiatric Rehabilitation Services.

PSYCHIATRIC REHABILITATION EXCEPTION LETTER

CHESTNUT RIDGE COUNSELING SERVICES, INC.

As a Licensed Practitioner of the Healing Arts, I am referring the following individual for participation in CRCSI's Psychiatric Rehabilitation Program even though he/she has a diagnosis other than a severe and persistent mental health diagnosis:

Consumer Name:

This individual has the following Diagnostic Criteria:
Problem 1:

The individual is interested in increased functioning in the following Psychiatric Rehabilitation domain(s):
☐ Residential ☐ Vocational ☐ Educational ☐ Social ☐ Wellness/Self-Maintenance

Brief description of the individual's current status relative to selected domain(s):

Brief description of the necessity for the individual to utilize Psychiatric Rehabilitation services to become successful and satisfied in an environmental role in the indicated domain area(s):

Signature of Ordering/Referring Licensed Practitioner of the Health Arts **Date**

Printed Name of Licensed Practitioner of the Health Arts

☐ **MD** ☐ **DO** ☐ **CRNP**
☐ **PA** ☐ **LCSW** ☐ **LPC**

NPI # _____ **PA Promise ID** _____