

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

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

Address Street _____

City _____ **State** _____ **County** _____ (only individuals currently residing in Fayette County are eligible)

Home Phone _____ **Cell Phone** _____ **Alternative Phone** _____

Primary DSM Diagnosis & Code:

Plus Functional Deficit Area(s) Checked Below

For Ages 14 + we accept the following diagnoses: Major Depressive disorder, Bipolar disorder, Anxiety disorders, Post Traumatic Stress disorder, Schizophrenia, Schizoaffective disorder, Borderline Personality Disorder, and Other Specified schizophrenia spectrum and other psychotic disorder. **For any other diagnosis**, the attached exception letter should be completed and signed by the LPHA to necessitate Psychiatric Rehabilitation Services due to a moderate to severe functional impairment in the area(s) marked below.

Check 1 or More Below

Functional Areas Needing Improvement

	Living - <i>Independent Living Skills, Meal Preparation, Cost effective Shopping, Money Management, Using public transportation, Linking to Resources and Community Services, housing assistance</i>
	Educational/Vocational/Work/Volunteering
	Social – <i>Development of healthy Relationships, development of natural supports, friendship development, development and linkage with positive leisure/recreation/hobbies, Communication Skills</i>
	Wellness/Self Maintenance - <i>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</i>

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 Healing Arts **Date**

Printed Name: _____ **MD** **DO** **CRNP** **PA**
Licensed Practitioner of the Healing Arts **LCSW** **LPC**

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

NPI# _____ **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# _____

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

**Fax Completed & Signed Form to (724) -437-3221 Any Questions? Call
724-438-5530**

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. The individual has a moderate to severe functional impairment in one of the following areas, and it is anticipated that Psych Rehab Services will help with goal achievement.

Consumer:

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 LPHA

Date

Printed Name: _____

NPI:
MA Promise ID: