Program of Wellness, Empowerment and Recovery
Psychiatric Rehabilitation Services Referral Form
110 S. First Street, Lehighton, PA 18235
Phone: 610-377-3940 Fax: 610-377-4026

Referral Guidelines

1. Participant must be 18 years or older and must reside in Carbon or Schuylkill county.
2. The individual must have a written recommendation for Psychiatric Rehabilitation Services from a Licensed Practitioner of the Healing Arts.
3. The individual must have a presence or history of a serious mental illness based on medical documentation which includes one of the following: **Schizophrenia Spectrum and other psychotic disorders, Bipolar and related disorders, Depressive disorders and/or Personality disorder.**
4. The individual must have moderate to severe functional impairment that interferes with at least one of the following domains: Self-maintenance, Educational, Vocational, or Socialization. These impairments must be caused by the presence of the mental illness.
5. The individual must choose to receive Psychiatric Rehabilitation Services.
6. Exception: Individuals who do met meet the serious mental illness diagnosis may receive services if the following conditions are met: **A. Written recommendation by a LPHA includes a diagnosis of mental illness listed in the DSM-V or ICD-9 or subsequent revisions, B. Includes a description of the functional impairment resulting from the mental illness.**

Referral Information

Date of Referral:	Agency:
Agency Contact:	Address:
Person Completing Form:	Phone:
Email:	Fax:
Is the consumer agreeable to this referral:	Relationship to the participant:

Participant Information

Name:	Date of Birth:
Address:	Social Security #:
Home Phone:	Gender:
Cell Phone:	Marital Status:
Email:	Housing Type:

Emergency Contact:	Address:
Home Phone:	Cell:
Email:	Relationship to Participant:

Insurance:

MA Recipient Number:	Other Insurance:
Access Card: _____ Yes _____ No	Access Card Number:

Professional Supports

Psychiatrist

Name:	Agency:
Address:	Phone:
Last Visit:	Fax:

Therapist

Name:	Agency:
Address:	Phone:
Last Visit:	Fax:

Personal Physician

Name:	Agency:
Address:	Phone:
Last Visit:	Fax:

Case Manager

Name:	Agency:
Address:	Phone:
Email:	Fax:

Representative Payee

Name:	Agency:
Address:	Phone:
Email:	Fax:

Other Supports

Name:	Agency:
Address:	Phone:
Email:	Fax:

Other Supports

Name:	Agency:
Address:	Phone:
Email:	Fax:

Mental Health & Physical Health History

Past Mental Health Treatment:(Type of program, dates, locations, within the last 6 months)

Past Drug and Alcohol Treatment:(Type of program, dates, location)

Medical Conditions:

Physical Limitations/Accommodations needed:

Additional Information: *Please attach the following*

☐ Current Medication List	☐ Most recent Psychiatric Evaluation

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Instructions: This form **MUST** be completed and signed by a Licensed Practitioner of the Healing Arts (Physician , MD, DO, CRNP, PA or psychologist). Referrals can and will not be processed until the Recommendation for Psychiatric Services Form is competed and returned. If you have any questions or need assistance please contact our office.

Recommendation for Psychiatric Rehabilitation

Participants Name:	Date of Birth:
County of Residence:	Social Security #:

Psychiatric Information: *Check all that apply*

	Diagnosis Category	Specific Diagnosis	DX Code
	Schizophrenia spectrum/ psychotic disorders		
	Bipolar & Related Disorders		
	Depressive Disorders		
	Personality Disorders		
	Other:		

Role Performance: *Check all that apply*
(As a result of the mental illness, the person has a moderate to severe functional impairment that interferes with or limits functioning in at least one of the following.)

	Domain	**Description of Impairment**
	Self-Maintenance	
	Vocational	
	Educational	
	Socialization	

Reason for PRS recommendation:

_____
_____
_____
_____
_____
_____
_____

By signing below I am recommending the above named individual for Psychiatric Rehabilitation Services

_____ _____ _____
LPHA Signature Printed Name Date