RESOURCES FOR HUMAN DEVELOPMENT

POWER
Program of Wellness, Empowerment & Recovery
Psychiatric Rehabilitation Services
110 S. Frist St. Lehighton, PA 18235
Phone: 610-377-3940 Fax: 610-377-4026

REFERRAL

DIRECTIONS: Please return this completed form, along with a **Psychiatric Evaluation signed by a psychiatrist or MD, and an updated Medication List to: RHD POWER 110 S. First St. Lehighton, PA 18235 or FAX to (610) 377-4026.**

Date of referral: _____

Name: _____ Birth Date: ____ / ____ / ____

Address: _____ City, State, Zip _____

Home Phone: _____ Cell Phone: _____ SSN: _____

EMERGENCY CONTACT Family member, guardian, or significant other to be notified in case of emergency:
Name: _____ Relationship: _____ Phone: _____

Address: _____ City, State, Zip: _____ Cell Phone: _____

A. HEALTH AND SOCIAL SERVICE INFORMATION

	Name	Agency	Phone
Psychiatrist			
Therapist			
Case Manager			
Medical Doctor			
Peer Support			
Probation/Parole Officer			
Housing			
Other			

List any medical problems or physical disabilities, especially those that would limit physical activities or those that require assistive technology or an interpreter:

_____

B. SOURCE OF INCOME

☐ SSI ☐ SSDI ☐ VA ☐ Job ☐ Other: _____

Does the member have a representative payee? ☐ No ☐ Yes If yes, please specify: _____

C. HEALTH INSURANCE

Medical Assistance ID#: _____ Medical Assistance Provider: _____

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D. CLINICAL HISTORY

1. INPATIENT HOSPITALIZATION HISTORY (Add additional pages if needed)

Facility/Address	From	To

Has the applicant ever exhibited or made threats of harm to self or others? If so, explain.

_____

_____

2. OUTPATIENT TREATMENT HISTORY (Add additional pages if needed)

Facility/Address	From	To

3. CURRENT MEDICATIONS (Add additional pages if needed)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

4. MEDICAL NECESSITY

<u>MUST</u> MEET <u>ONE</u> OF THE CATEGORIES A or B *<u>Check box and attach supporting documentation</u>*

A. Diagnosis

☐ Schizophrenia, Schizotypal, Delusional and/or mood disorder. **(F20.XXX-F29.XXX)**
Diagnosis Code:_____

☐ Mood [affective] Disorder. **(F30.XXX-F39.XXX)**
Diagnosis Code:_____

☐ Borderline Personality Disorder **(F60.3)**
Diagnosis Code:_____

B. Diagnosis Exceptions:
<u>All boxes must be checked and supporting documentation attached.</u>

☐ This individual does not meet the serious mental illness diagnosis criteria.

☐ Written Recommendation by a LPHA which includes a diagnosis of mental illness listed in the DSM-V or ICD-9 or subsequent revisions.

☐ A description of the functional impairment resulting from the mental illness.

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E. FUNCTIONAL ASSESSMENT

For each area, please rate on a scale of 0 to 5 the level of assistance the applicant needs or desires. Please identify the change that the applicant wishes to make in that domain, if any. **Please note that regulations state that scores of "moderate assistance" (3) or above in at least one domain meet criteria for medical necessity for this service.**

0- Needs no assistance
1- Needs minimal assistance
2- Needs some assistance
3- Needs moderate assistance
4- Needs substantial assistance
5- Needs extensive assistance

Scale	Domain	Describe needs and goals in each domain
_____	Living/Self-Maintenance:	Needs: _____
		Goals: _____
_____	Learning:	Needs: _____
		Goals: _____
_____	Working:	Needs: _____
		Goals: _____
_____	Socializing:	Needs: _____
		Goals: _____

F. REFERRED BY (Please print):

Name: _____ Title: _____
Agency: _____ Phone: _____
Signature: _____ Email: _____

G. APPLICANT'S SIGNATURE:

My signature indicates that this referral has been discussed with me, and I am in agreement with it.

Applicant's Signature: _____ Date: _____

REFERRAL CHECKLIST – All applicants will need to provide the following items:

☐ Completed referral form (this form)	☐ Psychiatric evaluation signed by an MD or psychiatrist. Must be current within 2 years.
☐ Signed Release of Information form	☐ Recommendation signed by a LPHA (MD, OD, PA, CRNP or psychologist **(see page 4)**

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RECOMMENDATION FOR PSYCHIATRIC REAHBILIATION SERVICES FORM

TO: Unit Director, RHD POWER
FROM: _____
DATE: _____
RE: Recommendation for Referral to RHD POWER PSYCHIATRIC REHAB PROGRAM

Name: _____ Birth Date: ____ / ____ / ____

Address: _____ City, State, Zip _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Diagnosis:	**Diagnosis Codes:**
Schizophrenia, Schizotypal, Delusional and/or mood disorder. ☐ **(F20.XXX-F29.XXX)** ☐ Mood [affective] Disorder. **(F30.XXX-F39.XXX)** ☐ Borderline Personality Disorder **(F60.3)** ☐ Other:_____	

Role Performance: *Describe the moderate to severe functional impairment that interferes with or limits functioning within the domain.*	
Domain	Description of Impairment
Living	
Learning	
Work	
Social	

Reason for Recommendation: (How will this individual benefit from Psych Rehab Services?):

_____ _____
Signature of LPHA Date

_____ _____
Printed Name of LPHA Title

_____
NPI Number

Note: In accordance with Pennsylvania guidelines and regulations for Psychiatric Rehabilitation Services, this recommendation must be signed by a "physician or licensed practitioner of the healing arts (LPHA) acting within the scope of professional practice." **Persons who are considered to be an LPHA currently only include Medical Doctors (MD, OD) Certified Registered Nurse Practitioners (CRNP), Physician's Assistants (PA)** or **Licensed Psychologist.**

The referral cannot be considered to be complete without this signed recommendation.