363 Third Street
Beaver, PA 15009
Phone: (724) 775-2298 Fax: (724) 774-7603

PSYCHIATRIC REHABILITATION SERVICES

Instructions: This form **MUST** be completed and signed by a **Physician, Psychologist, PA or CRNP**.
Referrals will not be processed until this letter is completed and returned.
If you have questions or need assistance, please contact our office.

- The individual must be at least 18 years of age.
- Due to MH diagnosis, there is moderate to severe functional impairment that limits the role performance in one of the four areas: Living, Learning, Working, or Social

RECOMMENDATION LETTER

Psychiatric Rehabilitation Services are specialized therapeutic interactions conducted by trained professionals who assist people with a psychiatric disability to choose, get and keep the roles that are important to them in the living, learning, working, and socializing environments. Psychiatric Rehabilitation Services are self-directed and person centered with a recovery focus. They facilitate the development of recovery skills. Services are multi-faceted and include, but are not limited to, individual advocacy, crisis management support, illness management and skills training.

I ______________________________________recommend ____
(LICENSED PROFESSIONAL OF HEALING ARTS-PRINT NAME) (PRINT PARTICIPANT NAME)

for Psychiatric Rehabilitation Services at Aurora Services.

MH Diagnosis: ____ICD-10 Code: _____________

Qualifying diagnoses: Schizophrenia, Major Mood Disorder, Psychotic Disorder NOS, Schizoaffective disorder, Borderline Personality

Exception request: If the individual does not currently meet the criteria for diagnostic eligibility, it is my recommendation that the individual would benefit from psychiatric rehabilitation services. In accordance to 5230.31 Admission requirements (3)(c): if an individual does not meet the serious mental illness diagnosis requirement they may receive services when the following conditions are met: (1) includes a diagnosis of a mental illness listed in the DSM-IV-TR or ICD 9 or subsequent revisions and/or (2) there is a description of a functional impairment resulting from the mental illness in at least one of the domain areas: Living, Learning, Working and/or Socialization. It is my recommendation that the individual receives these services.

Medically necessary criteria for recommendation:

____

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Please indicate evidence of functional impairments: (THIS SECTION MUST BE COMPLETED)

LIVING	**Moderate or Severe** **Explain:**
LEARNING	**Moderate or Severe** **Explain:**
WORKING	**Moderate or Severe** **Explain:**
SOCIALIZATION	**Moderate or Severe** **Explain:**

____ _______________________________

SIGNATURE OF REFERRING PERSON with Credentials **DATE**

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

____ _______________________________

NPI # **AGENCY**

Updated 6-13-23