CORNERSTONE CROSSING
119 RAILROAD ST.
BEDFORD, PA 15522
PHONE: (814) 623-8481
FAX: (814) 623-2864

CORNERSTONE CROSSING PSYCHIATRIC REHABILITATION REFERRAL FORM

Psych Rehab will accept referrals for people that meet the admission requirements according to the general rule of Pennsylvania Code - Title 55 - Chapter 5230.31. These requirements are:

- The person is at least 18 years of age.
- Documentation of a mental health diagnosis (see qualifying diagnoses on page 2).
- There is moderate to severe functional impairment due to the diagnosis that limits role performance in one of four areas: Education, Social, Vocational, or Self-Maintenance.
- The person chooses to participate in the program.

Participant Name: _____ **EMR ID #:** _____

Address: _____

Telephone: _____ **Birth Date:** _____

Social Security #: _____ **MA #:** _____

Date of Most Recent Hospitalization (if applicable): _____

Please check a specific track:

- ☐ Site-Based Psychiatric Rehabilitation
- ☐ Mobile Psychiatric Rehabilitation
- ☐ Transitions (Transition Age Youth 18-25)

Please mark areas affected:

- ☐ Educational
- ☐ Social
- ☐ Vocational
- ☐ Living

Person making referral: _____ **Telephone Number:** _____

Agency: _____

Why are you referring this participant? How does their diagnosis affect their living, learning, social and work environment?

_____

_____

_____

_____

Qualifying Diagnoses:

-Schizophrenia and other specified schizophrenia spectrum and psychotic disorder
-Schizoaffective disorder
-Major depressive disorder
-Bipolar disorder
-Borderline personality disorder
-Anxiety disorder
-Posttraumatic stress disorder

Diagnosis: Code:

Exception Request: Although the individual does not currently meet the criteria for diagnostic eligibility, he/she would benefit from Psych Rehab services. It is my recommendation that he/she receives these services. If the individual does not meet diagnostic criteria, please complete the attached Exception Request Form (page 3).

Licensed Professional of Healing Arts Signature & Title (Physician, PA, CRNP, LCSW, LMFT, LPC, Licensed Psychologist)

Date

Print Licensed Professional of Healing Arts Name & Title (Physician, PA, CRNP, LCSW, LMFT, LPC, Licensed Psychologist)

Date

MA #

NPI #

Somerset Psychiatric Rehabilitation

Exception Request Form

Name:_____

Diagnosis:_____

Although this individual does not currently meet the criteria for diagnostic eligibility, he/she would benefit from Psychiatric Rehabilitation Services. It is my recommendation that he/she receive these services. As a result of mental illness, this individual has moderate to severe functional impairment that interferes with or limits performance in at least one of the following domains: Living, Learning, Working, and/or Socializing.

The following is a description of the functional impairment/s this individual experiences and how he/she would benefit from Psychiatric Services:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of LPHA:_____ Date:_____