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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:



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