Psychiatric Rehabilitation Referral

Community Counseling Center
2201 E. State Street
Hermitage, PA 16148
724-981-6193

Name: _____ DOB: _____ BSU#: _____

Address: _____ SS#: _____

Phone: _____ Referral Source Name & Phone: _____

Type of Insurance: _____ Ins. ID #: _____

Presenting need or area of improvement (circle one): living wellness learning working socializing

Specific reason for referral: _____

_____

Number of total hospitalizations: _____ How many in the past year: _____

Current medications: _____

_____

Diagnosis including/ICD 10 Code:

1. 3. 5.

2. 4. 6.

Source and date of diagnosis: _____

*Description of Functional Impairment:_____

_____

Additional resources/agencies being utilized: _____

_____

_____ _____

Referral Source Signature Date

Healing Arts Professional Signature: _____

(MD, Psychiatrist, Psychologist, Nurse Practitioner, Phy. Asst., LPC, LMFT, LCSW)

Print Name: _____

I understand that the information provided is true and correct to the best of my knowledge.

I acknowledge that my signature gives permission for the CCC staff to discuss my case with agency/staff person submitting this referral.

Consumer Signature: _____ Date: _____

Referral Signature: _____ Date: _____

***Referrals will not be accepted without complete diagnosis/ICD 10 code-Healing Arts Professional Signature- and Description of Functional Impairment**