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**