Veni Vidi Vici
WELLNESS CENTER

Referral For Psychiatric Rehabilitation Program (PRP)

This form must be completed by a **Licensed Mental Health Professional**

1. **Referral Date:**

_____

2. **Clients Information:**

First Name:

_____

Last Name:

_____

Email:

_____

Phone Number:

_____

Date of Birth:

_____

3. **Legal Guardian Information (If applicable):**

First Name:

_____

Last Name:

_____

Guardians phone number:

_____

Guardians Email:

_____

Relationship to client:

_____

4. **Referral Source (Agency):**

_____

5. **Name & Credentials of Referring Provider:**

_____

6. Provider NPI number

_____

7. Referring Agency Phone Number:

_____

8. Adult Diagnosis(es) (the patient must have at least one of the following diagnoses to qualify for PRP):

- ○ F20.0 Paranoid Schizophrenia
- ○ F20.1 Disorganized Schizophrenia
- ○ F20.2 Catatonic Schizophrenia
- ○ F20.3 Undifferentiated Schizophrenia
- ○ F20.5 Residual Schizophrenia
- ○ F20.81 Schizophrenic Disorder
- ○ F20.89 Other Schizophrenia
- ○ F25.0 Schizoaffective Disorder, Bipolar Type
- ○ F25.8 Other Schizoaffective Disorders
- ○ F20.9 Schizophrenia, Unspecified
- ○ F25.1 Schizoaffective Disorder, Depressive Type
- ○ F25.9 Schizoaffective Disorders
- ○ F22 Delusional Disorder
- ○ F28 Other Psychotic Disorder
- ○ F31.2 Bipolar I Disorder, manic, severe w/psychotic ft
- ○ F31.5 Bipolar I Disorder, depressed, severe w/psychotic ft
- ○ F31.64 Bipolar I Disorder, mixed, severe w/psychotic ft
- ○ F33.3 MDD, severe w/psychotic ft
- ○ F31.0 Bipolar I Disorder, hypomanic
- ○ F31.13 Bipolar I Disorder, manic, severe
- ○ F31.4 Bipolar I Disorder, depressed, severe
- ○ F31.63 Bipolar I Disorder, mixed, severe w/o psychotic ft
- ○ F31.81 Bipolar II Disorder
- ○ F31.9 Bipolar Disorder, Unspecified
- ○ F33.2 MDD, recurrent, severe w/o psychotic ft
- ○ F60.3 Borderline Personality Disorder

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_____

9. Youth Diagnosis(es) (Any diagnosis can qualify a minor for PRP services):

_____

10. Client's Additional Diagnosis(es), include ICD-10 codes & descriptions:

_____

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_____

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11. Clinical Justification Brief statement of the functional impairments or skill deficits that PRP services will address (e.g., independent living, social skills, self-care, employment/education support, accessing community resources)

_____

_____

_____

_____

Clinicians Signature

_____

Signature