Divine Wellness , Inc
Psychiatric Rehabilitation Referral Form

Benefits/Entitlements
MA#:
Medicare #:
Other:
SSI:
SSDI:

Client Name: _____ Date: _____
Please provide answers to all the questions and attach supporting documents.

Send completed referral forms by email to: refer@divinewellnessinc.com

Client Information		
Client Preferred Name:		Social Security #:
Client Address:		Date of Birth:
Client Phone: (Home): (Mobile):		Gender : ____Male _____ Female
Physical Description:		
Primary Care Physician:		
Address: Phone:		
Current DSM 5 Behavioral Diagnosis	DSM Code	Diagnosing Physician
Diagnosis:	Code:	Name:
Diagnosis:	Code:	Date:
Diagnosis:	Code:	
Diagnosis	Code:	
Medical Diagnosis:		Date:

History of Hospitalization: _____ Yes _____ No Most Recent Year: _____

Reasons for Referral/ Medical Necessity

Requires 3 of the following areas of impaired function lasting 2 years continuously or intermittently

_____ Social Behaviors requiring intervention of Mental Health Systems.
_____ Inability to attend school without support or to maintain employment.
_____ Need assistance with basic living skills.
_____ Inability to develop, establish and/or maintain positive support system.
_____ Cognitive impairment leading to the inability to live in environment of choice.

Please include documentation to support the choices, i.e. Most recent psychiatric/ psychological evaluation, treatment plan, list of medications and other relevant documents.

I _____ refer _____ who satisfies for Divine Wellness, Inc. PRP Services.

_____ _____ _____
Signature of Referring Source/Credentials Printed Name of Clinician Date