Starting Point Mobile Psychiatric Rehabilitation Services LPHA Recommendation Form

Must be completed by a psychiatrist, doctor, certified registered nurse practitioner, psychologist, LMFT, LPC, or LCSW

Name of Person being referred: _____
Date of Birth: (at least 18 years or older) _____

Admission Criteria:

Please indicate one of the following five qualifying diagnoses and ICD-10-CM Code:

☐ Schizophrenia
ICD-10-CM code:____

☐ Major mood disorder
ICD-10-CM code: ____

☐ Psychotic disorder NOS
ICD-10-CM code:____

☐ Schizoaffective disorder
ICD-10-CM code:____

☐ Borderline personality disorder
ICD-10-CM code:____

☐ Post Traumatic Stress Disorder
ICD-10-CM code:____

☐ Anxiety disorder
ICD-10-CM code:____

If Requesting an Exception:

1. Diagnosis and ICD-10-CM Code:

_____

_____

2. Please provide a brief statement outlining the functional impairment as a result of diagnosis:

_____

_____

_____

As a result of mental illness, **there is the presence of a limitation in at least one of the following areas** (functional impairment), check all that apply:

☐ Educational (e.g. Obtaining a degree, taking classes)

☐ Social (e.g. Developing social support system, attending activities and groups in the community)

☐ Vocational (e.g. Obtaining and maintaining employment, resume writing, interviewing)

☐ Self-maintenance (e.g. Managing symptoms, managing money, living independently)

This referral and recommendation has been discussed with the person being referred and they are agreeing to participate.

_____ _____ _____
Practitioner's Signature and Credentials | PLEASE PRINT NAME | DATE

Please send referral and most recent psychiatric and medical evaluations to: spreferrals@accessservices.org