LEDC
LIFE ENRICHMENT DAY CENTER
CARING & COMPASSIONATE FAMILY BUSINESS

1522 Vaughn Road
Burlington, NC 27215
Telephone: 336-270-5155
Fax: 336-270-5156

PSYCHIATRIC REHABILITATION SERVICES REFERRAL FORM

LEDC accepts referrals from individuals who meet specific criteria to ensure optimal service delivery.

- The person is at least 18 years of age.
- The person has a severe mental illness documented by a psychiatrist or authorized professional. These may include but are not limited to schizophrenia, major mood disorder, substance abuse disorder, psychotic disorder NOS, schizoaffective disorder, or borderline personality disorder.
- Due to the MH diagnosis, moderate to severe functional impairment limits the role performance in one of four areas: Education, Social, Vocational, or Self-Maintenance.
- The person chooses to participate in the program.

Participant Name: _____ Address: _____

Telephone: _____SSN#: _____ Race: _____ Birth Date: _____

Housing Type: _____ Name of Facility (if applicable): _____

Insurance Type: ☐ Medicaid ☐ Medicare ☐ Uninsured Medicaid # (if applicable) _____

County/LME: _____ Date of last hospital visit: _____ Reason: _____

Please check the areas affected: ☐ Educational ☐ Social ☐ Vocational ☐ Self-maintenance ☐ Other: _____
Special Accommodations: ☐ Physical Disability ☐ Other: _____
Referral Source: _____ Agency: _____ Telephone: _____

What is the reason for referring this participant? How does their diagnosis affect their living, learning, social, and work environment? _____

DIAGNOSIS:	CODE:	DIAGNOSIS:	CODE:

Exception Request: While this person may not meet the diagnostic eligibility criteria, they could greatly benefit from LEDC services. Therefore, I strongly recommend that they receive these services. If the individual fails to meet the requirements, kindly fill out the Exception Request attached to this form.

Licensed Professional & Title
(Physician, PA, CRNP, LCSW, LMFT, LPC, Licensed Psychologist)

_____ Date _____

Print Licensed Professional Name & Title
(Physician, PA, CRNP, LCSW, LMFT, LPC, Licensed Psychologist)

_____ Date _____

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Exception Request Form

Name: _____

Axis I Diagnosis: _____

Although this individual does not currently meet the criteria for diagnostic eligibility, they would benefit from Psychiatric Rehabilitation Services. It is my recommendation that they receive these services. As a result of mental illness, this individual has moderate to severe functional impairment that interferes with or limits performance in at least one of the following domains: Living, Learning, Working, and Socializing.

The following is a description of the functional impairment/s this individual experiences and how they would benefit from Psychiatric Services:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of LPHA: _____ Date: _____