Recommendation Form

CORNERSTONE CLUBHOUSE

1041 W. Bridge St. Suite 10, Phoenixville, PA 19460
Phone: 610-935-2290 Fax: 610-935-2393
cornerstoneclubhousepa@gmail.com

I recommend _____ (Date of Birth _____) for Psychiatric Rehabilitation Services (PRS) provided at Cornerstone Clubhouse.

I am cordially invited to learn about this supportive environment and may do so by calling 610-935-2290 and arranging a tour.

Axis I Diagnosis is (circle those that apply):

Schizophrenia | Major Mood Disorder | Psychotic Disorder NOS | Schizoaffective Disorder | Borderline Personality Disorder

Other _____

As a result of the diagnosis, there is a moderate to severe functional impairment that interferes with/limits performance in the following area (circle those that apply):

Vocational | Educational | Living | Wellness | Social

Other _____

_____ Date

_____ Print Name

_____ Signature of a Licensed Practitioner of the Healing Arts (circle the Pennsylvania license)

Physician

Physician's Assistant

Certified Registered Nurse Practitioner

Psychologist

* Accredited by Clubhouse International * Member of Pennsylvania Clubhouse Coalition *
A Program of Holcomb Behavioral Health Systems

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Updated: 5/31/23