

Psychiatric Rehabilitation Readiness Determination

This form is to be used for Rehabilitation Readiness Development for the process of building an Individual's skills to proceed with rehabilitation goals. The purpose is to assess and assist the individual to increase the functioning of an Individual with psychiatric disabilities so that he/she can succeed in a community environment of living, working, learning, and social relationships.

| Data Field | Identifying Information Instructions |
|---|---|
| Organization and Program Name | Record the names of the Organization and the Program if applicable |
| Individual's Name | Record the first name, last name, and middle initial of the Individual being served. Order of name is at agency discretion. |
| Record # | Record your agency's established Record number for the Individual. |
| Date of Birth | Record the date of birth of the Individual. (e.g. MM/DD/YYYY) |
| Data Field | Current Environments |
| Living, Working, Learning, Socializing | Complete the columns provided for each rehabilitation environment listed. Describe perceptions, reactions, need for change, and existing/needed skills and supports as expressed by the individual, family, and/or other involved individuals. Note the goals the individual intends to achieve. Using the boxes to the left of each environment, rank (using the numbers 1 to 4) the individual's priorities for change. |
| Data Field | Readiness Criteria and Ratings |
| Readiness Criteria and Ratings | Using the rating criteria provided, rate each of the 4 areas on the next page (page 3) (Living, Working, Learning, and Socializing) according to each criteria (Need for Change, Commitment to Change, Environmental Awareness and Self Awareness). Enter the appropriate scores on page 3. |
| Conclusions and Recommendations | Indicate recommendations and strategies for increasing rehabilitation readiness or for participation in the psychiatric rehabilitation process. |
| Data Field | Signatures |
| Completed by: Print Name, Credential, Sign, and Date | The staff member who completes this form is to print name, specify credentials (if applicable), sign his/her name, and record the date of completion. |
| Team Leader/Clinical Supervisor: Print Name, Credential, Sign and Date (if applicable) | The Team Leader/Clinical Supervisor who reviews this form is to print name, specify credentials (if applicable), sign his/her name, and record the date of completion. |