

# Client Referral Form



Fax completed form to Central Scheduling at 914-347-8859

Today's Date	/ /	Last Name			First Name		
Sex on Insurance				Gender Identity	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	<input type="checkbox"/> Transgender Woman/Female <input type="checkbox"/> Transgender Man/Male <input type="checkbox"/> Choose Not To Disclose	
Date of Birth		/ /					
		Month		Day		Year	
<i>Your answers to the following questions will help us reach you quickly and discreetly with important information.</i>							
Address	Street			City	State	Zip Code	
Type of Residence	<input type="checkbox"/> Private Residence <input type="checkbox"/> DSS/ACS Agency Boarding/Foster Home <input type="checkbox"/> Homeless (Shelter/Street/Transitional Living Center)			<input type="checkbox"/> Incarcerated <input type="checkbox"/> Nursing Home or Health-Related Facility <input type="checkbox"/> Other: _____			
Mobile Phone	( ) -				<input type="checkbox"/> OK to Leave Message – Mobile Phone		
Other Phone	( ) -				<input type="checkbox"/> OK to Leave Message – Other Phone		
Email Address						<input type="checkbox"/> Email is Shared	
Preferred Language				Secondary Language			
Special Communication Needs	<input type="checkbox"/> None Reported <input type="checkbox"/> TDD/TTY Device		<input type="checkbox"/> Language Interpreter Services <input type="checkbox"/> Sign Language Interpreter		<input type="checkbox"/> Other Describe: _____		
Special Physical Accommodations (If yes, please describe)							

Does the client have insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Insured		
Insurance			ID/Policy #	
			Medicaid # (if applicable)	
Additional Insurance			ID/Policy #	
			Medicaid # (if applicable)	

*If different from client, please provide the information below.*

Insured Name				
Date of Birth	Month / Day / Year	Social Security #	-	-

Emergency Contact			Phone #	( ) -
Relationship			Preferred Language (if other than English)	
Address	Street		City	State Zip Code

*If client is a minor, please provide the information below.*

Parent/Guardian Name			Phone #	( ) -
Address	Street		City	State Zip Code
Preferred Language (if other than English)			Relationship	

Referral Source (Organization)			Referral Contact (Person)	
Primary Reason for Referral				
Referral Source Address				
Referral Contact Phone #	( ) -	Email		

*If applicable, please fill out the hospital referral information below.*

<b>Recently Hospitalized</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>COPS Referral (Hospital Inpatient)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hospital</b>		<b>Discharge Date</b>	/ /
<b>Discharge Paperwork Sent</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, when will it be sent:</i> _____	
<b>Receiving Injectable Medication</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Next Due Date</b>	/ /
<b>Injectable Medication/Dosage</b>			
<b>On Clozaril</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Next Blood Draw</b>	/ /

*Please select a service location.*

<input type="checkbox"/> <b>White Plains</b> 360 Mamaroneck Ave White Plains, NY 10605	<input type="checkbox"/> <b>Mt Kisco</b> 344 Main Street- Suite 301 Mt Kisco, NY 10549	<input type="checkbox"/> <b>Yonkers</b> 20 South Broadway- Suite 402 Yonkers, NY 10701	<input type="checkbox"/> <b>Upper Nyack</b> 311 N. Midland Ave- Suite #3 Nyack, NY 10960	<input type="checkbox"/> <b>OnTrack NY</b> 20 South Broadway- Suite 402 Yonkers, NY 10701
<input type="checkbox"/> <b>Valley Cottage</b> 104 Route 303 Valley Cottage, NY 10989				

*For school referrals only*

<input type="checkbox"/> <b>Nyack Middle School</b> 98 South Highland Avenue Nyack, NY 10960	<input type="checkbox"/> <b>Nyack High School</b> 360 Christian Herald Rd, Nyack, NY 10960	<input type="checkbox"/> <b>North Rockland High School Extension</b> 65 Chapel Street, Garnerville, NY 10923
<input type="checkbox"/> <b>Fieldstone Middle School</b> 100 Fieldstone Drive, Thiells, NY 10984	<input type="checkbox"/> <b>North Rockland High School</b> 106 Hammond Road, Thiells, NY 10984	

*Please select services you are interested in.*

<input type="checkbox"/> Care Management/Manager	<input type="checkbox"/> Peer Outreach
<input type="checkbox"/> CORE Services	
<input type="checkbox"/> SUD/Credentialed Alcoholism & Substance Abuse Counselor (CASAC)	
<input type="checkbox"/> Therapy	<input type="checkbox"/> Therapy & Medication Management
<input type="checkbox"/> Family Support	
<input type="checkbox"/> Employment Services	
<input type="checkbox"/> Therapy & Medication Management for someone who has been affected by a loved one who has struggled with substance use	

**Please fax form to (914)347-8859 attention Central Scheduler.  
If this form is incomplete scheduling can be delayed.**