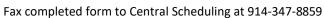
Client Referral Form





Today's Date	/	/	Last Na	ame					First	Name			
Sex on Insurance						Gend Ident	_	☐ Femal ☐ Male ☐ Other	е	☐ Transg ☐ Transg ☐ Choose	ender Ma		le
Date of Birth / / Month Day Year													
Your answers to the following questions will help us reach you quickly and discreetly with important information.													
Address	,							Zip Code					
Type of Residence	□ Private Residence □ Incarcerated □ DSS/ACS Agency Boarding/Foster Home □ Nursing Home or Health-Related Facility □ Homeless (Shelter/Street/Transitional Living Center) □ Other:												
Mobile Phone ()				_					OK to Leave Message – Mobile Phone				
Other Phone			() –							☐ OK to Leave Message – Other Phone			Phone
Email Address									☐ Email is Shared				
Preferred Language							Secondary Lang			ge			
Special Communication Needs	☐ TDD/TTY Device ☐ Sign Language Interpreter ☐ Describe:												
Special Physical Accommodations (If yes, please describe)													
Does the cli	ve 🗆	e ☐ Yes ☐ No			Relationship to Insured			d					
Insurance					ID/Policy #								
surunce						Medicaid # (if applicable)							
Additional						ID/Policy#							
Insurance						Medicaid # (if applicable)							
				If diff	erent from o	client, pleas	e provi	ide the info	rmatio	n below.			
Insured Name									I				
Date of Bir	th	/ Month Day			/ Year	Year Social Securit			ty#				_
Emergency Co	ntact							Phone	# ()	_	•	
Relationshi	ip					Pre	eferre	d Languag	e (if o	ther than	English)		
Address		Street City State Zip Code											
				If c	lient is a mii	nor, please p	provide						
Parent/Guardi	an Nam	ne						Pl	hone #	ŧ ()		
Address			Str	eet			City			State	1	Zip Code	
Preferred Language (if other than English) Relationship													
Referral Source (Organization)								Refer	ral Cor Person)	ntact			
Primary Reason for Referral													
Referral Source Address													
Referral Conta	ct Phor	ne# ()		-			Email					

If applicable, please fill out the hospital referral information below.									
Recently Hospitalized	□ No	COPS Referral (Hospital Inpatient) ☐ Yes ☐ No							
Hospital		Discharge Date	/ /						
Discharge Paperwork Sent ☐ Yes ☐ No If no, when will it be sent:									
Receiving Injectable Medication	☐ Yes ☐ No	If Yes, Next Due Date	/ /						
Injectable Medication/Dosage									
On Clozaril	☐ Yes ☐ No	If Yes, Next Blood Draw	/ /						
Plance colect a comice location									
Please select a service location.									
White Plains 360 Mamaroneck Ave White Plains, NY 10605 Mt Kisco, NY 1	et- Suite 301 20 South Broadway- Sui								
□ Valley Cottage 104 Route 303 Valley Cottage, NY 10989									
For school referrals only									
Nyack Middle School Nyack High School									
98 South Highland Avenue Nyack, NY 1096	0 360 Christian Herald Rd, Nyack, NY 10960								
☐ Fieldstone Middle School 100 Fieldstone Drive, Thiells, NY 10984	☐ North Rockland H 106 Hammond Road, T	_	North Rockland High School Extension Chapel Street, Garnerville, NY 10923						
Please select services you are interested in.									
☐ Care Management/Manager									
☐ CORE Services									
☐ SUD/Credentialed Alcoholism & Substance Abuse Counselor (CASAC)									
☐ Therapy & Medication Management									
☐ Family Support	3		-						
☐ Employment Services									
☐ 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.