Client Referral Form

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

greater mental health of New York

Today's Date	/ /	**Last Name**		**First Name**	
Sex on Insurance		**Gender Identity**	☐ Female ☐ Male ☐ Other ☐ Transgender Woman/Female ☐ Transgender Man/Male ☐ Choose Not To Disclose		
Date of Birth	/ / Month Day Year				

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Address	Street	City	State Zip Code
Type of Residence	☐ Private Residence ☐ DSS/ACS Agency Boarding/Foster Home ☐ Homeless (Shelter/Street/Transitional Living Center)	☐ Incarcerated ☐ Nursing Home or Health-Related Facility ☐ Other: _____	
Mobile Phone	( ) –	☐ OK to Leave Message – Mobile Phone	
Other Phone	( ) –	☐ OK to Leave Message – Other Phone	
Email Address		☐ Email is Shared	
Preferred Language		☐ **Secondary Language**	
Special Communication Needs	☐ None Reported ☐ TDD/TTY Device ☐ Language Interpreter Services ☐ Sign Language Interpreter ☐ Other Describe: _____		
Special Physical Accommodations (If yes, please describe)			

Does the client have insurance?	☐ Yes ☐ 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.			
Recently Hospitalized	☐ Yes ☐ 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**	/ /

Please select a service location.

☐ **White Plains**
360 Mamaroneck Ave
White Plains, NY 10605

☐ **Mt Kisco**
344 Main Street- Suite 301
Mt Kisco, NY 10549

☐ **Yonkers**
20 South Broadway- Suite 402
Yonkers, NY 10701

☐ **Upper Nyack**
311 N. Midland Ave- Suite #3
Nyack, NY 10960

☐ **OnTrack NY**
20 South Broadway- Suite 402
Yonkers, NY 10701

☐ **Valley Cottage**
104 Route 303
Valley Cottage, NY 10989

For school referrals only

☐ **Nyack Middle School**
98 South Highland Avenue Nyack, NY 10960

☐ **Nyack High School**
360 Christian Herald Rd, Nyack, NY 10960

☐ **Fieldstone Middle School**
100 Fieldstone Drive, Thiells, NY 10984

☐ **North Rockland High School**
106 Hammond Road, Thiells, NY 10984

☐ **North Rockland High School Extension**
65 Chapel Street, Garnerville, NY 10923

Please select services you are interested in.

☐ Care Management/Manager

☐ CORE Services ☐ Peer Outreach

☐ SUD/Credentialed Alcoholism & Substance Abuse Counselor (CASAC)

Therapy ☐ Therapy & Medication Management

☐ Family Support

☐ 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.