Client Referral Form

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

greater mental health of New York

Today's Date		Last Name		First Name		Date of Birth	

Sex on Insurance		Gender Identity	☐ Female ☐ Transgender Woman/Female ☐ Other ☐ Male ☐ Transgender Man/ Male ☐ Choose not to disclose

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 ☐ Incarcerated ☐ Homeless (Shelter/Street/Transitional Living Center) ☐ Nursing Home or Health-Related Facility ☐ Other: _____

Mobile Phone		☐ OK to Leave Message - mobile	Other Phone		☐ OK to Leave Message - other

Email Address		☐ Email is Shared

Preferred Language		Secondary Language	

Special Communication Needs	☐ None Reported ☐ TDD/TTY Device ☐ Language Interpreter ☐ Sign Language ☐ Other: _____

Special Physical Accommodations (If yes, please describe)	

Primary Care Physician Name		Phone	
		Fax	

Please check off if any of the following applies to you:

☐ Criminal History ☐ Suicide Risk ☐ Recent Discharge from Psych or Substance Use Treatment ☐ Sex Offender
☐ Parole/ Probation ☐ Assisted Outpatient Treatment (AOT) ☐ Assertive Community Treatment (ACT) ☐ Eating Disorder
☐ History of Agression ☐ Medication Assisted Treatment ☐ Chronic Health Conditions: _____
☐ Co-Occuring Disorder: _____ ☐ History of or Current Substance Use Disorder: _____

Does the client have insurance?	☐ Yes ☐ No	Relationship to Insured	

Insurance		ID/ Policy #		Additional Insurance		ID/ Policy #	
		Medicaid #				Medicaid #	

If different from client, please provide the information below.

Insured Name		Date of Birth		Social Security #	

Emergency Contact Name		Phone		Relationship		Preferred Language	

Address	Street _____ City _____ State _____ Zip Code _____

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

Parent/ Guardian Name		**Phone**		**Relationship**		**Preferred Language**	
Address	Street		City		State		Zip Code

Referral Informration

Referral Source		**Referral Contact**	
Primary Reason for Referral			
Address	Street	City	State / Zip Code
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.

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

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

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

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

For school referrals only

☐ **Nyack Middle School**
98 South Highland Ave
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 ☐ Community Oriented Recovery and Empowerment (CORE) Services ☐ Therapy

☐ Peer Outreach ☐ Employment Services ☐ Family Support ☐ Therapy & Medication Management

☐ Substance Use Disorder /Credentialed Alcoholism & Substance Abuse Counselor (CASAC) *(White Plains Clinic Only)*

☐ Therapy & Medication Management for someone who has been affected by a loved one who has struggled with substance use

For information on all services and programs offered by Greater Mental Health of New York, please visit our website: greatermentalhealth.org

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