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| **Client Information**:  Client Name:  DOB:  SS#:  What pronoun do you use? ( ex:He, She , They):\_\_\_\_\_\_\_\_\_\_\_\_\_  Gender:  Male Female Transgender  Race: (check all that apply)  American Indian or Alaska Native  Asian  Black or African American  Hispanic  Native Hawaiian or Pacific Islander  White  Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Decline  Current grade:  School District:  Address:    Other family members in the Home:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone #:  Can we leave a message?  Yes  No  Email Address: | **Insurance:**  **All Insurance Information must be completed and a copy of insurance cards must be provided.** (Self-pay with a sliding scale is available)  **Primary Insurance**:  Excellus Family Health/Child Health Plus MVP  Monroe Plan Aetna Independent Health BC/BS of Rochester BC/BS of Western NY  Medicaid  other (please specify):  Policy Number:  Policy Holder's Name:  Relationship to Client:  **Secondary Insurance**:  Excellus Family Health/Child Health Plus MVP  Monroe Plan Aetna Independent Health BC/BS of Rochester BC/BS of Western NY  Medicaid  other (please specify):  Policy Number:  Policy Holder's Name:  Relationship to Client:  **Responsible Party: (ONLY IF DIFFERENT THAN THE PATIENT)**  Name:  Address:  Phone:  Relationship to Client: |
| **Parent/Guardian Contact Information:**  **Under 18 years**  Name:  Email Address:  Address:  **Over 18:**  Emergency Contact (name and phone number):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Referral Source Contact Information:**  Name:  Email Address:  Address:    Phone #: |
| **Reason for Referral:**  **Any use of drugs or alcohol?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Alcohol being used(amount/frequency):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Substances being used, amount and frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Last use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Previous Treatment providers (inpatient and outpatient):**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Current Medication Provider?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Other current providers:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **High Risk/High Priority Issues:** (i.e. suicide attempts or thoughts, significant mental health concerns, pregnancy, Need for medications, IV drug user etc)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Other Factors Impacting Participation:** (i.e. probation, placement, parent/guardian, etc.)  Check boxes ,  DHS  Domestic Violence  housing  CPS  school  Probation  Court: Type (criminal, family, mental health, drug)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **\*\*This Program is an outpatient clinic and it is not licensed or equipped to operate as an emergency room, a crisis center, a detoxification center, or a psychiatric unit. I understand that the person I am referring is in need of a Behavioral health evaluation and is not exhibiting acute medical or psychiatric issues.**    **Signature Date** | |
| **OFFICE USE ONLY:**  **Insurance:**  **Medicaid/Managed Care Plan**  **Private insurance**  **Referral for:**  **Mental Health**  **Substance Use**  **Suboxone**  **Health Homes**  **BH HCBS: Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Therapist assigned:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Appointment date/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |