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| **Client Information**:Client Name: DOB: SS#: What pronoun do you use? ( ex:He, She , They):\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ]  Male [ ] Female [ ] TransgenderRace: (check all that apply)[ ]  American Indian or Alaska Native [ ]  Asian [ ]  Black or African American [ ]  Hispanic [ ]  Native Hawaiian or Pacific Islander [ ]  WhiteEthnicity:[ ]  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 [ ]  NoEmail 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |