Date Referral Received: ______________ Staff Initials ______________ Clinic ID #: ____________________________

The Nathaniel Clinic

Youth (13-17 years) Referral Form

First Name ___________________________ **Last Name** ____

Age _____ **DOB** ____________ **Gender** ______________ **SSN** ______ - _____ - __________

Main Phone ________________________ Home Cell **OK to Call Client?** Yes No

Alternate Phone ______________________ Home Cell **OK to Call Client?** Yes No

Primary Email Address ______________________________________

Street Address ____ **Apt.** ____________

City ____ **Zip Code** __________________

Parent/Guardian First Name _________________________ **Last Name** ____________________________

Parent/Guardian Primary Contact Number ____

OK to Call Parent/Guardian? Yes No

Parent/Guardian Alternative Contact Number ____

OK to Call Parent/Guardian? Yes No

Race

Asian Black/African American White or Caucasian
Native American Multiracial Native Hawaiian/Other Pacific Islander

Ethnicity Non-Hispanic Hispanic

Smoking Status Never Smoked Former Smoker Current Smoker

Primary Language ______________________________________

Referral Source Name of Agency ____

Referral Contact Name ____

Referral Contact Phone Number ____

Referral Contact Email ____

Health Insurance Status *(Choose all that apply)*

Medicaid   Child Health Plus   Commercial Parent/Guardian

Insurance Pending   Not Eligible for Health Insurance

Health Plan *(Choose one)*

Affinity	Amerigroup	Amida Care	Emblem
Fidelis Care	Healthfirst	HIP	Group Health Insurance
Metro Plus	UnitedHealthcare	WellCare	

Other *(Please indicate plan name)* ________________

PLEASE TELL PARTICIPANT/PARENT/GUARDIAN TO BRING HEALTH INSURANCE CARD(S) TO FIRST APPOINTMENT

NYSID ___________________

Criminal Justice Status

ATD   Probation   Parole   Treatment Court

Secure Detention   Reentry   Youth Program _________________________

Justice Involvement Details (include date of arrest, conviction, admission and release from custody, the intake offense and conditions of release, probation, special release conditions, etc)

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Next Court Date/Probation Appt./CJ Program Appt. ______________________________

Name Probation Officer, Juvenile/CJ Provider ______________________________

Title ______________________   **Contact Number** ______________________

Email ______________________   **Fax** ______________________

Name School/Education Provider ______________________________

Education Status ______________________________

School/Education Provider Primary Contact ______________________________

Please fax to (212) 222-2318

Parental/Guardian Notification (provide details of notification provided to parent/guardian about the referral to mental health treatment. Consent in writing/verbal for clinic to start assessment. Notification of parent/guardian of requirement that they attend assessment and availability to attend with their child the assessment)

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Check All That Apply

- Court System Referral (Open Legal Case)
- Discharged Inpatient Psych Facility 60 days (No services)
- Foster Care Aging Out (Currently no services)
- Managed Care Urgent Care Referral
- Youth Referred Home Based
- Crisis Intervention Program (HBCI)
- Youth Leaving RFT or RTC
- CPEP/Psychiatric ER Referral
- DV Shelter Client (Not in treatment)
- Juvenile Justice
- Mobile Crisis Client (Not in treatment)
- Rape Crisis Center Referral
- Runaway and Homeless Youth

Reason Seeking Services (Include information about other providers case manager, education, vocational training, family court, ACS contact information involved in coordinating care)

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Desired Therapist Gender Male Female No preference

Primary Language ______________________________

Best Time for Services

Monday Tuesday Wednesday Thursday Friday Saturday 9am-5pm

Morning Afternoon Weekday Evenings 5pm-9pm

Please attach any of the following documents, if available

- Current list of **ALL** medications
- Most Recent Psychiatric Evaluation & Most Recent Psychosocial Assessment
- Jail/Prison Discharge Summary & Correctional Health Records
- Most Recent Annual Physical & Lab Results

CASES internal information, if available

- Plea agreement or Court Admission Note with specific ATI/D requirements
- Bring down RAP sheet for therapist to review or attach legal history summary
- Program Screening/Orientation Information including any screens completed/Supervision Plan
- PHQ-9 Modified for Teens, CRAFFT, UCLA,
- CASES Consent Forms signed by participant/guardian

Please fax to (212) 222-2318