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

The Nathaniel Clinic

Adult 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** ___________________

Race

Asian Black/African American White or Caucasian

Native American Multiracial Native Hawaiian/Other Pacific Islander

Ethnicity Non-Hispanic Hispanic

Marital Status Single Married Divorced Separated Widowed

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 ____

Source of Income SSI or SSDI No Income PA/TANF Wages/Salary Child Support

Health Insurance Status *(Choose all that apply)*

Medicaid Medicare Dual Medicare & Medicaid

Medicare Supplemental Commercial No 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 CLIENT TO BRING HEALTH INSURANCE CARD(S) TO FIRST APPOINTMENT

NYSID ___________________

Criminal Justice Status

ATD ATI Misdemeanor Probation Felony Probation Parole

Treatment Court Jail Reentry Prison Reentry Federal Probation

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. ____

Do any of the following categories apply to your client?

Assisted Outpatient Treatment

AOT Details

____

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____

Please fax to (212) 222-2318

Check All That Apply

Court system referral (Open Legal Case)

CPEP/Psychiatric ER Referral

Discharged Inpatient Psych Facility 60 days (No services)

DV Shelter Client (Not in treatment)

Foster Care Aging Out (Currently no services)

Juvenile Justice

Managed Care Urgent Care Referral

Mobile Crisis Client (Not in treatment)

Youth Referred Home Based

Rape Crisis Center Referral

Crisis Intervention Program (HBCI)

Runaway and Homeless Youth

Youth Leaving RFT or RTC

Homeless adult

Reason Seeking Services (Include information about the individual's participation and status in the CASES program, other providers care manager, housing case manager, shelter staff, ATI/D, probation and parole officer staff contact information involved in coordinating care)

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Desired Therapist Gender Male Female No preference

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 mental health assessments
- Most recent psychiatric evaluation
- Most recent psychosocial assessment
- Jail/Prison discharge summary & correctional health records
- AOT current order
- 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
- PHQ-9, TCU DSII, UCLA, PCL-C
- Copy of signed service plan
- Consents signed

Please fax to (212) 222-2318