FOR ELECTRONIC USE



Date Referral Completed:

**ARC HEALTH SERVICES**

**2060 BRIGHTON-HENRIETTA TOWNLINE RD**

**ROCHESTER, NY 14623**

**(585) 271-0661**

**(585) 244-2871 FAX**

Referral Form

Arc Health Services serves OPWDD eligible adults

CONFIDENTIALITY NOTICE:

Once information is entered on to this document it is becomes part of the medical record for the individual named. The guidelines & procedures used for medical records should be applied to this document, including but not limited to appropriate filing, distribution and (if indicated) disposal. The record should not be photocopied, nor distributed to any individual/agency without appropriate written authorization. If the appropriate inter-provider and/or inter-agency release(s) of information have been signed, distribution of this record is authorized as follows: Patient’s Mental Health Clinic Chart, Patient’s Residential Facility Chart, Patient’s Program Facility Chart, & Service Coordinator/Case Manager Patient Record. If appropriately authorized via signed release(s) of information, further distribution may be permitted to collateral care providers, school personnel, & family members.

***Individual’s Demographic Information***

Legal Name:       DOB (mm/dd/yyyy):

SS#:

Address:

Type of Residence:       Agency (if applicable):

Phone      Please Specify (staff, personal, cell, etc.):

Ethnicity (from DDP1):

Does applicant have a legal guardian?  Yes  No

Guardian name:

Address:

Phone #:

Email address:

*\* Guardian must be notified and must give consent for the service being requested.*

***Clinic Services Needed***:

On-going service: One time service:

Physical Therapy (prescription required)  Sexual Consent Determination Evaluation

Psychiatric

Speech

Individual Social Work Counseling

Group Social Work Counseling (Please specify group requested)

Nutrition (if being referred for Diabetes or Renal Disease counseling, a prescription is needed)

Occupational therapy (prescription required)

Describe reason for service: (explain reason for each requested service, **please be specific**):

Does the individual need an interpreter?  Yes  No

If yes, please indicate type of interpreter needed:

***Care Coordinator***

Name:

Email:

Agency:

Phone:

Fax:

***Person Referring***

Person completing form:

Relationship to individual:

Email Address:

Agency (if applicable):

Address:

Phone:

**Contact to schedule intake or first appointment**

Name:

Agency (if applicable):

Relationship to individual:

Email Address

Phone:

***Insurance***

Medicaid #:

Medicare #:

Other:       ID#:

Insured's Name:

Address:

Subscriber:     

***Medical Background:***

**Developmental Diagnosis:**

**Mental Health Diagnosis**:

**Medical Diagnosis**:

***Primary Providers***

Primary Care Physician:

Address:

Phone:

Cell/Pager/Other:

Fax:

Psychiatrist Name:      

Address:

Phone #:

Cell/Pager/Other:

Fax:

**Please see the documentation checklist for the required documentation that needs to be submitted with the referral**.