Penfield School  EMHCS  Villa VOCA Program  Juvenile Justice Therapy Program

Type of Referral:

Individual  Family  ARES  Impaired Driver System

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| **Client Information**  **Date Completed:** Click or tap here to enter text.  **Client Name:** Click or tap here to enter text.  DOB: Click or tap here to enter text. SS#: enter text here  Phone #: Click or tap here to enter text.  *Can we leave a message?*  Yes  No  Address: Click or tap here to enter text.  Email Address: Click or tap here to enter text.  Preferred method of contact: Click or tap here to enter text.  Assigned Sex at Birth:  Male  Female  Gender Identity & Preferred Pronouns (optional):  Sexual Orientation (optional):  Race: (check all that apply)  American Indian or Alaska Native  Asian  Black or African American  Hispanic  Native Hawaiian or Pacific Islander  White  Declined  Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined  Primary Language: Click or tap here to enter text.  Preferred Language (Family):  Interpreter needed (what language):    Have you previously been seen at the Villa of Hope Behavioral Health Outpatient Clinic?  No  Yes  If yes, what was the reason for leaving/discharge? Click or tap here to enter text.  Do you have family members or other people significant to you that attend our locations?  No  Yes - If yes, name:    Are you receiving mental health and/or substance use therapy elsewhere?  No  Yes – If yes, please specify what is being treated:        **Reason for Referral/Primary Concerns *Please be as specific as possible.***    **Other Contributing Factors / Reasons For Participation:**  Court Ordered: Type -  (criminal, family, drug, mental health)  CPS Mandated  DHS requirement  Domestic Violence  Housing Concerns  School  **Therapy Modality or Other Specific Requests:**  EMDR  DBT  Art Therapy  Female Therapist  Male Therapist Other:  For all youth, and for Medicaid eligible adults:  Would you be interested in learning about any other services at The Villa of Hope?  No  Yes | | ***Complete if UNDER 18 Years Old:***  Is this youth in foster care?  Yes  No  ***If yes,*** Name of County worker:  Phone # of worker:  Email address of worker:  **Legal Guardian- Contact Information:**  Does legal guardian have custody of the youth:  Yes  No  Name: Click or tap here to enter text. Relationship: Click or tap here to enter text.  Phone #:  Email Address: Click or tap here to enter text.  Name any individual who should not be aware of services or be involved:  Name:       Relationship:  Name:       Relationship:  Name:       Relationship:  ***Complete if OVER 18 Years Old:***  Emergency Contact Name:  Relationship:  Phone #:  **Insurance: All insurance information must be completed and a copy of insurance cards must be provided.** (Self-pay with a sliding scale is available). **If insurance is a Medicaid Manage Care Plan, we need a CIN number as well.**  Billing address same as home/mailing address?  Yes  No If no:  **Primary Insurance:**  Family Health/Child Health Plus  Excellus  Independent Health  MVP / Beacon  BC/BS of Rochester  BC/BS of Western NY  Medicaid  Medicare  Aetna  Other (please specify): enter text here  Policy Number: Click or tap here to enter text.  Policy Holder’s Name: Click or tap here to enter text.  Relationship to Client: Click or tap here to enter text.  **Secondary Insurance:**  Family Health/Child Health Plus  Excellus  Independent Health  MVP / Beacon  BC/BS of Rochester  BC/BS of Western NY  Medicaid  Medicare  Aetna  Other (please specify): enter text here  Policy Number: Click or tap here to enter text.  Policy Holder’s Name:  Relationship to Client:  **Responsible Party (ONLY IF DIFFERENT THAN THE CLIENT):**  Name:  Address:  Phone:  Relationship to client:  **Safety Assessment**  We understand if these questions may be difficult to answer at this time. If you are able to, please answer honestly so we can assure you receive the appropriate care and accommodations. **MUST BE COMPLETED**  Within recent memory…   1. Have you harmed yourself in any way?   No  Yes -If yes, when was the last time? 2. Have you had thoughts of suicide?  No  Yes -If yes, when was the last time?       Have you made an attempt before?  No  Yes Do you currently have a plan?  No  Yes 3. Have you physically harmed another person (excluding defending yourself or others)?   No  Yes -If yes, when was the last time?  **Current Primary Care Physician (Optional):**  Name of Doctor/Practice:  Address:  Phone #:  **Current Medication Provider (Optional):**  Name of Doctor/Practice:  Address:  Phone #: | |
| **Referral Source Contact Information:**  Name: Click or tap here to enter text.  Relationship to referred individual:  Phone #:  Email Address:  Company (if applicable):  Address: | | ***For DWI /DWAI Impaired Driver System Referrals only:***  Inform individual it may be only 1 visit  (but can sometimes require additional meetings).  DWI Court Ordered  Suspended License  Obtained copy of:  Violation documentation from court  Copy of driver’s license  Next court date is:  \*\*\*Contact Jasmin to schedule client session\*\*\* | |
| **Review with referral source:** | | |
|  | *This program is an outpatient clinic and 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 (or myself) is in need of a Behavioral Health evaluation and is not exhibiting acute medical or psychiatric issues*  *If unable to attend the scheduled appointment, cancellation needs to be no less than 24 hours before the appointment by calling 585-328-0834.*  *Please note that should the referred individual not be able to attend the intake session it may be several weeks before next available intake.* | |