NYFS Northeast Youth & Family Services

DAY TREATMENT REFERRAL FORM

Please attach supporting documents. For example, diagnostic assessment, H&P, discharge planning from hospital or another day treatment program, psychological evaluation, progress notes with diagnosis and symptoms, and/or IEP if applicable

Date: _____

Has Client Previously Been Seen at NYFS? Y or N

Client's Legal Name: _____

Clients Preferred Name (If applicable): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

County: _____

Age: _____ DOB: _____ Gender: _____ Preferred Pronoun: _____

Referred by: _____ Relationship to Client: _____

How did you hear about us? _____

Telephone Number: _____

Guardian/Caregiver Name(s): _____

Guardian/Caregiver Telephone Number(s): Cell: _____ Work: _____

Guardian/Caregiver Email(s): _____

School District & School: _____Grade: _____

Primary Diagnosis: _____

Has client had previous mental health involvement? If yes, please explain.

_____

_____

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PAGE 2

Will an interpreter be needed for the screening and intake process? Y or N

Reason for referral or intake: _____

_____

_____

_____

Subscriber Insurance information

Name: _____

Street Address: _____

DOB of insured: _____ Relationship to Client: _____

Primary Insurance Information

Name of Insurance: _____

Group **#**_____ Member ID#_____

Secondary Insurance Information (If applicable)

Name of Insurance: _____

Group **#** _____ Member ID#_____

If you are the insurance holder, please sign below, indicating that we have permission to bill your insurance

X _____

Return to NYFS by fax to 651-486-3858 (Attn: Day Treatment) or by email to Molly.Kummer@nyfs.org
***Please attach supporting documents listed at the top of the form, thank you! ***