THE Arc MADISON CORTLAND CLINIC SERVICES REFERRAL

This referral is for services at the following location(s) – Not all services are available at all the locations

___Clinic Admission ___Additional Clinic Services ___Specialized Assessment

□ Oneida □ Cortland
□ Utica □ Rome □ Turin □ Marcy □ Kirkland

DATE REFERRAL MADE: _____ DATE REFERRAL RECEIVED: _____

DEMOGRAPHIC AND INSURANCE INFORMATION – MUST COMPLETE ALL LINES

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Primary Diagnosis: _____

Living Situation:

□ IRA – List Agency it is operated by: _____

□ Family Care – List Agency it is overseen by: _____

□ With Family – Relation to referred individual: _____

□ Independent

Insurance Information:

Medicaid Number: _____ Medicare Number: _____

Other Insurance (Fidelis, BC/BS, etc)

Insurance Name: _____ Policy Number: _____

Insurance Name: _____ Policy Number: _____

Referring Party Information:

Referring Individual: _____ Agency: _____

Email Address: _____ Phone Number: _____

Person to Contact to Schedule: _____ Relation: _____

Email Address: _____ Phone Number: _____

REFERRAL REQUEST – SELECT ALL THAT YOU ARE REQUESTING – PRESCRIPTION FROM PCP REQUIRED FOR ALL THAT HAVE (**) NEXT TO THEM

ONGOING SERVICES

- ☐ Psychiatry
- ☐ Podiatry
- ☐ Social Work
- ☐ Behavior/Mental Health Counseling
- ☐ Physical Therapy**
- ☐ Occupational Therapy**
- ☐ Speech Therapy**
- ☐ Nutrition

SPECIALIZED ASSESSMENTS

- ☐ Eligibility Testing (Includes IQ and Functional)
- ☐ Full Scale IQ ☐ Functional Assessment
- ☐ Comprehensive Diagnostic Evaluation w/Functional
- ☐ Comprehensive Diagnostic w/Functional & IQ
- ☐ Guardianship ☐ Sexuality Assessment
- ☐ Healthcare Proxy ☐ Medical Consent
- ☐ Swallowing Evaluation** ☐ Sensory Assessment**
- ☐ Wheelchair ** ☐ Adaptive Equipment**
- ☐ Other: _____

Reason for Request (Please describe to the best of your ability the behavior, deficit or problem. Also indicate what other services may have been attempted to address this):

_____

_____

_____

_____

_____

REQUIRED ATTACHMENTS FOR THE REFERRAL

CLINIC ENROLLMENT FOR ONGOING SERVICES

- □ PCP script for OT, PT or ST Evaluation
- □ Medicaid Card
- □ Medicare Card (if applicable)
- □ 3rd Party Insurance Card (if applicable)
- □ Completed Insurance Form (if applicable)
- □ OPWDD Eligibility Letter and/or NOD
- □ Psychological Assessment
- □ LifePlan
- □ IEP (if currently enrolled in school)
- □ Legal Guardianship Paperwork (if applicable)
- □ Medication List and Last Visit Note (for psychiatry referrals only)

SPECIALIZED ASSESSMENTS (onetime evaluation)

- □ PCP script for Swallowing Eval, Wheelchair Assessment, Adaptive Equipment, Sensory Assessment
- □ Medicaid Card
- □ Medicare Card (if applicable)
- □ 3rd Party Insurance Card (if applicable)
- □ Completed Insurance Form (if applicable)
- □ LifePlan (if they have one)
- □ IEP (if enrolled in school or just aged out)
- □ Previous Psychological Assessments
- □ Medical Reports
- □ Letter from OPWDD requesting the Assessment (if already submitted to eligibility committee and they are requesting additional tests)

OFFICE USE ONLY

I have reviewed all of the medical documents forwarded to the Clinic related to the care of this individual and give my ____approval for the aforementioned services ____denial for the aforementioned services.

Medical Director's Signature_____ Date_____