The Arc Westchester Wellness Center Referral

265 Saw Mill River Road, Hawthorne NY 10532

Phone:914-495-4500 Fax: 914-328-3166

Thank you for your interest in The Arc Westchester Wellness Center services. Please complete the enclosed referral as well as all supporting documents.

The following documents are required for any service being requested:

- Current Life Plan or IEP
- Current Physical with Medications and lab work
- ALL INSURANCE CARDS (Clear copies of the front and back) (New Medicare Cards are required if you are Medicare eligible)

Additional documents that are required, depending on the service you are requesting.

- *PSYCHOLOGICAL AND/ OR PSYCHOSOCIAL EVALUATIONS Require*:
  - PREVIOUS PSYCHOLOGICAL
  - PREVIOUS Psychosocial

- *GUARDIANSHIP AFFIRMATION & AFFIDAVIT, Require:*
  - PREVIOUS PSYCHOLOGICAL (if applicable)
  - PREVIOUS PSYCHOSOCIAL (within the last 3 years)
  - PREVIOUS PSYCHIATRIC EVALUATION/ NOTES (if applicable)

- *PSYCHIATRY (EVALUATION & ON-GOING SERVICES) require*:
  - PREVIOUS PSYCHOLOGICAL (within the last 3 years)
  - PREVIOUS PSYCHOSOCIAL (within the last 3 years)
  - PREVIOUS PSYCHIATRIC EVALUATION/ NOTES (3 most recent)
  - NEUROLOGICAL EVALUATION/ NOTES
  - LIST OF MEDICATIONs
  - PREVIOUS PSYCHOSOCIAL/ SOCIAL HISTORY

- *PHYSICAL THERAPY, OCCUPATIONAL AND/OR SPEECH THERAPY require:*
  - PREVIOUS PHYSICAL/OCCUPATIONAL / SPEECH EVALUATION (if applicable)
  - PRESCRIPTION (within a year)

- *NUTRITION (EVALUATION & ON-GOING SERVICES) require*:
  - PREVIOUS NURTITION EVALUATION
  - WEIGHT HISTORY
  - PRESCRIPTION (within a year)
  - Recent LABS

- *PSYCHOTHERAPY requires:*
  - PREVIOUS PSYCHOLOGICAL (if applicable)
  - PREVIOUS PSYCHOSOCIAL (if applicable)
  - PREVIOUS PSYCHIATRIC EVALUATION/ NOTES (if applicable)

Identifying information:

First Name Middle Initial Last	Social Security #:	DOB:	☐ Male ☐ Female
Address: Own Legal Guardian? Agency: ☐ YES ☐NO			
Living Situation: ☐ IRA-Supervised ☐ IRA-Supportive ☐ ICF ☐ CR-Supervised ☐ CR-Supportive ☐ Family Home ☐ Independent ☐ Other _____ If OPWDD certified residence: Please provide the Name, title and contact number of the residence contact: _____			
Primary phone #:	Fax #:	Email:	
Ethnicity: ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ White ☐ Other _____		Primary language spoken if other than English:	
US Citizen: ☐ Yes ☐ No	Resident Alien: ☐ Yes ☐ No	Registered to Vote: ☐ Yes ☐ No	
Marital and Family Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered ☐ Unknown # of children: _____			
Educational level: ☐ Ungraded ☐ Some grade school ☐ Completed 8th grade ☐ High school diploma ☐ IEP diploma ☐ GED ☐ Post high school ☐ College level			
Developmental Disability (indicate all that apply): ☐ Autism ☐ Cerebral Palsy ☐ Epilepsy ☐ Intellectual deficit ☐ Learning Disability ☐ Neurological impairment ☐ Undetermined ☐None ☐ IQ: _____			

Personal representative's information:

Contact name:	Primary contact #:
Relationship:	Primary contact type: ☐ Home ☐ Work ☐ Cell
Legal guardian*: ☐ Yes ☐ No HIPAA Personal Representative? ☐ Yes ☐ No	Email: May we contact? ☐ Yes ☐ No

Emergency contact: (must be filled out)

Name:		Relationship:
Address:		City, State, Zip:
Day Telephone #:	Fax #	Cell Phone #

CCO information - if applicable:

Care Manager's Name:		Email:
CCO:	Address:	City, State, Zip:
Office #:	Cell #:	Fax #:

Day Program information/ School:

Day Program/ School Name:		Contact Name and number :
Agency:	Address	City, State, Zip:

Please list all other Clinical/Medical Services received including Article 28, Article 16 and Home Care Services:

Name of Provider	Type of Service	Contact Name and Phone #

Insurance (In addition to sending front and back copies of insurance cards):

Primary Insurance (name):
Secondary insurance (name):
Tertiary Insurance (name):

Additional Information:

General safety issues:	
Travel safety issues:	General medical concerns:
Anticipated mode of transportation to clinic services: ☐ Walk ☐ Family ☐ Para-Transit ☐ Public bus ☐ Other: _____	Unique skills, abilities, interests:

Services being requested:

☐ Psychosocial Evaluation	☐ Psychological/ Vineland II Evaluation
☐ Guardianship Evaluation	☐ Psychiatric Evaluation
☐ Psychiatry	☐ Psychotherapy/Counseling
☐ Physical Therapy	☐ Occupational Therapy
☐ Speech Therapy	

Describe reason(s) for referral: include functional and physical limitations, desired behavior issues to be addressed, recent hospitalizations and indicate if service is an emergency.

Referring Party Information:

Referring Party Name (And agency name if applicable):	Contact #: Fax #:
Address:	

Referring Party Signature:_____ **Date:**_____

For Clinic use only:
Authorization for Admission- The individual identified in this referral form is approved for admission to the Arc of Westchester Wellness Center for assessment and /or treatment

_____ _____
Dr. Nirenberg, MD, Medical Director **Date**