Behavioral Health and Wellness Center
A Division of Transitional Living Services of Northern New York
7550 S. State Street
Lowville, NY 13367
Phone: 315-376-5450 Fax: 315-376-7221
Website: www.tlsnny.com

**** Required Fields***
Date Taken: _____ Taken by: _____
Referral Source: _____

***Name:**

Last First MI
***DOB**: _____ *Gender: □Male □Female

****Mailing Address*:**

Phone Number: **OK to Leave Message?**
(___)_____(Home) □Y □N
(___)_____(Cell) □Y □N
(___)_____(Text) □Y □N
(___)_____(Work) □Y □N
Email Address: _____
Do you prefer a phone call, text, or an email regarding appts.?
Check all that apply:
□Home/Work Phone □Email □Cell Phone □Text

If a minor: Lives w/Mother □ Father □ Both □
Other _____
Parent/Guardian
Names:_____
Are there custody issues? Yes□ No□
If yes, please explain:

Please provide custody paperwork at time of appointment
The following people can bring child to appointment:
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

***County*:** Lewis Oneida Jeff St.Law. Herkimer
****School District*:** _____

Marital Status: Separated□ Divorce□ Married□ Single□ Widow□
SSN: _____
* Alias/a.k.a/Maiden Name:

***Current Insurance Coverage*:**

***Primary:**
Subscribers Name: _____
____ Medicare ____ Part A ____ Part B ____ Both
____ Medicaid
____ No Insurance
____ Other _____
Insurance ID#_____
***Secondary**: Yes No
Subscribers Name: _____
____ Medicare ____ Part A ____ Part B ____ Both
____ Medicaid
____ Other _____
Insurance ID#_____

****Emergency Contact:***

Name
_____
Phone (Work and Home)
_____
Relationship

*Primary Care Physician: _____

Other Provider: _____

Are you currently having any thoughts of harming yourself or others? Yes (crisis worker to be notified immediately) No

*Reason for referral/presenting problem:

_____

_____

_____

Service(s) being requested with this referral:

□Verbal Therapy □Court Ordered Evaluation

□ Medication evaluation and retention of care by Staff Psychiatrist □Comprehensive Psychological Evaluation

□One-time Medication consultation appointment with Staff Psychiatrist, care retained by the referral source

□Current medication (Please list)

_____

_____

*□ Individual has received mental health services in the past?

If so, provider or agency name: _____

Date last seen: _____

Scheduled Screening Appt: _____ Provider Name: _____
□ Release Form(s) mailed to client

_____
Referrerôs Signature Date

_____
Client Signature Date

□ cc