ICL EHR#: _____ Initials: _____

ICL Treatment Referral Form

(Check box of clinic referral should be directed to)

☐ **East New York Health HUB** **2581 Atlantic Avenue** **Brooklyn, NY 11207** **PHONE 718-495-6700** **FAX 718-485-4018**	☐ **Rockaway Parkway Center** **1310 Rockaway Parkway** **Brooklyn, NY 11236** **PHONE 718-272-3300** **FAX 718-927-1801**	☐ **PROS** **2581 Atlantic Avenue** **Brooklyn, NY 11207** **PHONE 718-495-6700** **FAX 646-829-1042**

Please email Referral Form to iclhope@iclinc.org

Demographic Information

Date:_____ Name:_____ Guardian's Name (for child):_____

Client's DOB:_____ Gender:Male ☐ ☐Female ☐Transgender SS No.: _____

Primary Insurance Name:_____ Primary Insurance Number:_____

Secondary Insurance Name:_____ Secondary Insurance Number:_____

Address: _____ Zip: _____

Phone: (H) _____ (W)_____ (Cell) _____

Primary Language: _____ ☐ Non-English Speaking

Service Preference: ☐ Phone only ☐ Video or Phone ☐ No telehealth, in-person only ☐ Video/Phone & In-person

Referred By: (Name):_____ Relationship to Client:_____

Organization:_____ Phone:_____ Email/Fax: _____

Reason for seeking treatment, including any symptoms: _____

_____

_____

Diagnoses, if known. Please include all psychiatric and medical diagnoses, including substance use disorders: _____

_____

_____

Medications: Please list all current medications, including those for mental and physical health. Please include date of the last prescription and the number of refills. For long-acting injectable medications, please indicate date of last injection, duration of injection, and due date.

Name of Medication	Dose, Route, Frequency	Date of Last Rx / IM	Duration of Last Rx/IM	Due date for next Rx/IM

(Check side box when answer to below questions is "yes")

☐ Is individual having serious thoughts about hurting themselves or trying to hurt themselves?

☐ Is individual having serious thoughts about hurting someone else or being hurt by someone else?

☐ Is individual or individual's child a survivor of severe trauma or sexual abuse within the last 6 months?

☐ Is individual currently hearing voices or seeing things that are frightening?

If yes to any of the above, please explain: _____

_____

Please email Referral Form to iclhope@iclinc.org or call 844-ICL-HOPE

FOR OFFICE USE ONLY:

Provider:_____ Day:_____ Date:_____ Time: _____