The Arc Mid-Hudson New York **Mid-Hudson Health Specialties** **Clinic Treatment Referral**	**Print Full Name:** Last First MI **Referral Source Information:** Name/Title/Agency/Address Telephone: Email:

Please include the following with your completed referral form:

- ☐ 1.) Copies of all medical insurance cards (front & back)
- ☐ 2.) PPD Results (If the individual is not currently enrolled in the clinic, 2 PPD tests within a year are required. However, if the individual is in an OPWDD Certified Program 1 test is necessary)
- ☐ 3.) Most recent Life Plan or IEP
- ☐ 4.) DDP-2 Form
- ☐ 5.) Guardianship decree (if relevant)
- ☐ 6.) Script required; PT, OT, Speech & Swallowing Evaluations: copies of prior evaluations
- ☐ 7.) Most recent psychological & psychiatric exam, Behavior Support Plan (if applicable); psychosocial (if available); and any other relevant documentation

Date of Referral:	**Insurance Information**
Date of Birth:	**Primary Insurance Info**
Sex:	Name of Insurance:
Soc. Sec. #:	Insurance ID#:
Residence:	Name of Insured:
Address:	Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Telephone:	Insured Soc. Sec. #:
Guardian Contact Information	Insured Date of Birth:
Guardian Name:	**Secondary Insurance Information**
Address:	Name of Insurance:
Telephone:	Insurance ID:
Email:	Address:
Emergency Contact Information	Name of Insured:
Emergency Contact Name:	Relationship to Insured: ☐Self ☐ Spouse ☐Child ☐Other
Telephone:	Insured Soc. Sec. #:
Email:	Insured Date of Birth:
Communication & Mobility	**Private Insurance**
Verbal: ☐ Yes ☐ No	Name of Insurance:
Communication Modality:	Insurance ID #:
Language:	Relationship to Insured: ☐Self ☐ Spouse ☐Child ☐Other
Mobility:	Insured Soc. Sec. #:
Supervision:	Insured DOB:
Services Requested:	
Reason for Referral:	
DD Diagnosis:	Other Diagnosis:
Additional Information (environmental factors, medical conditions/diagnosis, behavior problems, etc.):	
Transportation to appointments will be provided by (include name & phone #):	
Indicate other Clinical Services received elsewhere, name of certified clinic & day of reoccurring appointment:	
Medical Director: _____ Date:	

Please send referral and requested documents to:

Sherry Tesler, Treatment Coordinator
Mid-Hudson Health Specialties
139 Cornell St, Kingston, NY 12401
sherry.tesler@arcmh.org
Tel: 845-338-1234 ext. 42706 Fax: 845-338-6284