OnTrackNY
My health. My choices. My future.

NORTHERNRIVERS
NORTHEAST PARENT & CHILD SOCIETY
PARSONS CHILD & FAMILY CENTER
UNLIMITED POTENTIAL

OnTrackNY Referral

*Referral guidelines: To refer a potential client, please complete this form and return it, along with a signed Release of Information and relevant records, to **Joanne Schneider, 518.292.5451; fax, 518.447.0429; Joanne.Schneider@nrfs.org**.*

Client Information

Date of referral ______________________

Client name ______________________ Date of birth ______________________

Parent or guardian (if minor) ______________________

Address ______________________

Phone ______________________ Email ______________________

Insurance info ______________________ Policy holder ______________________

Referral Information

Referral name ______________________

Referral agency ______________________

Phone ______________________ Email ______________________

Psychiatrist ______________________ Phone ______________________

Is the client aware of and in agreement with this referral? ☐ Yes ☐ No

Does the client speak English? ☐ Yes ☐ No If no, indicate language ______________________

Indicate the degree to which the patient's family/caregiver is involved in treatment: ☐ Low ☐ Moderate ☐ High

Reasons for referral:

Relevant Medical, Psychosocial, and Psychiatric Information

Describe psychotic symptoms that the client has reported or demonstrated over the past 2 years (including onset and course of qualifying symptoms, and any self-harm, suicide attempts, or violent behavior):

Identify other psychiatric issues the client has reported or demonstrated over the past 2 years:

☐ Depression	If yes, describe symptoms and timeframe:
☐ Mania	If yes, describe symptoms and timeframe:
☐ Substance	Indicate type(s), time frame, amount, and frequency:
☐ Other	Describe:

Indicate whether the client has any of the following cognitive deficits:

☐ Intellectual and developmental disabilities	If yes, indicate severity:
☐ Learning disorder	If yes, indicate type:

Psychiatric History

Please provide a brief psychiatric history, including relevant information regarding (1) psychiatric hospitalizations, and (2) current and past medications:

Describe any known family psychiatric history:

Relevant Medical History

Describe any relevant medical history:

Working Diagnosis

Describe working diagnosis if obtained via medical records or from a provider.
Primary diagnosis:

R/O:

R/O:

Additional Information

Provide any additional information that may be relevant to this client's treatment (especially client's strengths, as well as important psychosocial history, family involvement, etc.):

Collateral Contact Information

To assist in determining eligibility, provide contact information for all applicable:

Primary Care Provider	
Psychiatrist	
Hospitals	
Psychological Testing	
Therapist	
Neurology	
Substance Abuse Treatment	
School Counseling or IEP/504	
College Counseling	
Other	