Urgent __
Routine __

Behavioral Health and Wellness Center

A division of TLS

7550 S. State Street, Lowville, NY 13367 Tel: (315) 376-5450 Fax: (315) 376-7221
482 Black River Parkway, Watertown, NY 13601 Tel: (315) 782-1777 Fax: (315) 785-8628

Name:

Last **First** **MI**

DOB: _____

Gender:
☐Male ☐Female ☐Transgender Female ☐Transgender Male
☐Non-binary ☐Gender Variant/Non-Conforming
☐Decline to answer ☐Prefer to self-describe _____

Marital Status:
Separated☐ Divorce☐ Married☐ Single☐ Widow☐

SSN: _____

Alias/AKA/Maiden Name: _____

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.?
☐Phone Call ☐Text ☐Email

If a minor: Lives w/Mother ☐ Father ☐ Both ☐
Other: _____

Parent/Guardian Name(s):

_____

Are there custody issues? Yes☐ No☐
If yes, please explain: _____

***Please provide custody paperwork at time of appointment**

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
_____
Relationship

The following people may transport my child to/from appts.:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

County: ☐Lewis ☐Oneida ☐Jefferson ☐St. Law. ☐Herkimer

School District: _____

Primary Care Physician: _____

Other Provider(s):_____

Location Preference (Lowville, Watertown, Health Center(s), School(s): _____
South Lewis Health Center; Beaver Falls Health Center
Lowville Academy and Central School, Copenhagen Central School, South Lewis Central School

Are you currently having any thoughts of harming yourself or others? ☐ Yes ☐No
-If yes, contact crisis worker immediately for further assessment.

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Please indicate any need for language/interpretation services; specify language spoken if other than English, below:

_____

Reason for referral/presenting problem: ☐ See attached

_____

Service(s) requested with this referral are:

☐ Psychotherapy; Individual/Family
☐ Psychiatric Evaluation and/or Continued Medication Treatment
☐ Court-Order Evaluation
☐ One-Time Psychiatric Evaluation/Consult
☐ Telemental Health Services: Psychotherapy and/or Medication Treatment (Synchronous video and voice will be required)

If you selected telemental health services, please indicate why this would be in the individual's best interest, understanding that this is not a guaranteed option; all requests for telemental health services will be reviewed by a multi-disciplinary team to assess the clinical appropriateness.

_____

All current medication (Please list **ALL** prescribed medications and any Over the Counter medications):

_____

Has the individual has received mental health services in the past? ☐Yes ☐ No

If yes, provider/agency name: _____ Date last seen: _____

Is client aware of referral: ☐ Yes ☐ No ☐ Self-Referral

Relationship to Client (if making the referral on behalf of the client): _____

_____
Completed by/Referral Source (Print) Date

_____
Client Signature Date

Please ensure all items are filled in/completed thoroughly, otherwise referral will not be process and will be returned to referral source for further information/details

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Office Use Only:

Initial Scheduled-Appointment Date/Time: _____ Provider Name: _____
Type of Appointment: _____