☐ 39-09 214th Place
Bayside, N.Y. 11361
Tel: (718) 229-5757
Email: clinic@shield.org

☐ 144-61 Roosevelt Avenue
Flushing, N.Y. 11354
Tel: (718) 939-8700
Fax: (718) 939-0881
Email: clinic@shield.org

The SHIELD Institute
Educating and Supporting New Yorkers with Developmental Disabilities

Article 16 Clinic

Referral Information Form/Face Sheet

PLEASE FILL THIS FORM OUT ENTIRELY – IT WILL BE SENT BACK IF INCOMPLETE!

DATE OF REFERRAL_____/_____/_____

Is transportation medically necessary? ◯ Yes ◯ No

Does the individual use a wheelchair? ◯ Yes ◯ No

Will someone accompany the individual? ◯ Yes ◯ No

Please include the following with referral: ***Any previous Psychological, Psychosocial, Medical (current), copy of insurance card(s), LifePlan/IEP***

For scheduling please contact:_____

Phone:_____

NAME:_____ **DOB:** _____ **AGE:** _____ **SEX:**_____

ADDRESS:_____ **City:** _____ **State:** _____ **ZIP:** _____

TYPE OF RESIDENCE: ◯ **FAMILY** ◯ **ICF** ◯ **IRA** ◯ **SUPPORTIVE APT.** **Name of Residential Agency:**_____

HOME PHONE:_____ **EMERGENCY CONTACT:**_____ **PHONE:**_____ **CELL:**_____

TABS #: _____ **MEDICARE #:**_____ **MEDICAID #:**_____ **SS#:**_____

OTHER INSURANCE/ TYPE & Policy #:_____ ◯ **NO INSURANCE**

PRIMARY DIAGNOSIS: _____ **LEVEL OF ID:**_____

PRIMARY LANGUAGE SPOKEN ◯ **ENGLISH** ◯ **OTHER:**_____

Please note, all testing is conducted in English. Can testing/services be conducted in English? ◯ **Yes** ◯ **No** ***You must bring a translator if needed!!!!!***

Please check preference(s) for Shield Clinic site (Please note: All services are not provided at all sites):

☐ Main Clinic site, Bayside ☐ Flushing Shield Satellite, Flushing
☐ Heartshare Satellite - Oakland Gardens ☐ Daybreak Independent Services Satellite - Bronx
☐ Human Care Services Satellite – Brooklyn

DOES THE INDIVIDUAL ATTEND ANY OTHER ARTICLE 16 CLINICS? [ ] NO [] YES, ***IF YES, please complete:***

PROVIDER'S NAME: _____ **TYPE OF CLINIC (IF KNOWN):**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

PHONE:_____ **FAX:**_____ **CONTACT PERSON:**_____

*Transportation for appointments can be arranged through Medicaid Answering Service (MAS) for individuals who DO NOT have managed care and for those individuals who cannot use public transportation. **Please provide the medical justification as to why this person cannot use public transportation or attend appointments** independently._____

SERVICE (S) REQUESTED THAT APPLY CHECK ALL

☐ **PHYSICAL THERAPY** ☐ **OCCUPATIONAL THERAPY** ☐ **PSYCHOTHERAPY** ☐ **SPEECH**
☐ **AUGMENTATIVE COMMUNICATION** ☐ **REHAB COUNSELING**
☐ **PSYCHOLOGICAL EVALUATION** ☐ **GUARDIANSHIP** ☐ **CITIZENSHIP**
☐ **PSYCHOSOCIAL EVALUATION** ☐ **PSYCHOSEXUAL EVALUATION**

REASON FOR REFERRAL (*PRESENTING PROBLEM - MUST INCLUDE MEDICAL NECESSITY*):_____

SOURCE OF REFERRAL (NAME):_____ **AGENCY:**_____

ADDRESS:_____ **CITY:**_____ **STATE:** _____ **ZIP:** _____

PHONE:_____ **FAX:**_____

E-MAIL ADDRESS:_____ **RELATIONSHIP:**_____

SEND REPORT(S) TO: ◯ **REFERRAL SOURCE** ◯ **CARE MANAGER** ◯ **OTHER:**_____

E-MAIL ADDRESS:_____

Is the primary caregiver and individual in agreement with this referral? ◯ **Yes** ◯ **No,** ***If no, attach explanation***

FOR OFFICE USE ONLY.

Prescription for Services: After review of this information, it is my professional medical opinion that this individual sufficiently meets all admission criteria to receive services provided by The Shield Institute Article 16 Clinic. This authorizes the performance of clinical evaluations necessary to develop a treatment plan and the provision of services on that treatment plan.

_____ _____
Medical Director Signature **Date**

SEND ALL REFERRAL PACKETS TO: Clinic@shield.org