**SASi ARTICLE 16 CLINIC**

**CLINIC SERVICE REQUEST**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Initial Referral** (for Initial Referrals please complete the entire form and send requested attachments)

**Additional Clinic Service Request** (for Individuals already receiving clinic services go directly to the clinic service requested section of this form and complete)

**CLINIC SERVICE REQUESTED:** (use a separate form for each service requested)

 Occupational Therapy\*  Psychiatry\*  Social Work  Speech Therapy

 Physical Therapy\*  Psychological Evaluation  Vocational Rehab

|  |  |  |
| --- | --- | --- |
|  | **A prescription from the person’s Primary M.D/active treating physician is required for: OT or PT** |  |

**THE FOLLOWING IS REQUIRED FOR AN INITIAL REFERRAL:**

Clinical records (evaluations/treatments relevant to this referral), **IEP/ISP/Life Plan and TABS Inquiry (if OPWDD enrolled)**

**REASON FOR REFERRAL (presenting problem):**

**Referred by**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_

If not care manager,was the person’s care manager notified? Yes No NA

**SEND COMPLETED REFERRAL AND ATTACHMENTS TO:**

**INTAKE COORDNATOR**

**960 West Maple Court**

**Elma, NY 14059**

**Phone: 716-805-1555**

**Fax: 716-805-1444**

**Email: Wsherwood@sasinc.org**

**OFFICE USE ONLY:**

PRESCRIPTION FOR SERVICES: AFTER REVIEWOF THIS INFORMATION, IT IS MYPROFESSIONALMEDICAL OPINION THAT THIS

INDIVIDUAL SUFFICIENTLYMEETS ALL ADMISSION CRITERIA TO RECEIVE SERVICES PROVIDED BY SASI ARTICLE 16 CLINIC. THIS AUTHORIZES THE PERFORMANCE OF CLINICAL EVALUATIONS NECESSARY TO DEVELOP A TREATMENT PLAN FOR THE SERVICES REQUESTED.

Medical Director Authorization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Coordinator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Assessment scheduled: \_\_\_\_\_\_\_\_\_\_\_\_\_