Admissions Department
1263 Delaware Ave.
Buffalo, NY 14209
Phone: (716) 886-8200 ext. 2264
Fax: (716) 777-7666

Referral Information Tool

DATE: _____ Time: _____

Referring Organization: _____

Referring Staff Name: _____

Facility Phone number: _____ Fax: _____

Patients Name:_____

Patients Phone Number : _____

Date of Birth: _____

Social Security Number: _____

Type of Insurance: _____

Insurance ID Number: _____

Insurance Guarantor (if different than patient): _____

Guarantor's Date of Birth: _____

Guarantor's Social Security Number: _____

Reason for Inpatient referral:

_____

_____

_____

_____

Medical History:

_____

_____

Previous Psych History? _____

Substance Abuse History? _____

If client being referred is a child, who has custody? _____

Parent/Guardian *must* accompany Child

Does child have IQ score or an Intellectual Disability? _____