SEVEN CHALLENGES REFERRAL

LIBERTY RESOURCES
Improving Lives, Building Futures

Integrated Health Care
1045 James Street, Syracuse, NY 13203
Family Health Center: Ph (315) 413-7865; Fax (315) 679-5990
Behavioral Health Center: Ph (315) 472-4471; Fax (315) 472-1759

Referral Application

Referral Date: _____ **Referred by:** _____ **Preferred Provider:** ☐ *Male* ☐ *Female* ☐ *Either*

Last Name	First Name	DOB

Gender:	Check Preferred Contact # ☐ Home Phone:	Mailing Address:		
SSN	☐ Cell Phone:	City	State	Zip

For Minors: Parent/Legal Guardian Name	Guardian's Relationship

Benefits & Responsibility:

Primary Insurance	Policy Number	Subscriber's Name	Subscriber's DOB

Subscriber's SSN	Subscriber's Employer	Subscriber's Relationship to Patient

Secondary Insurance ☐N/A	Policy Number	Subscriber's Name	Subscriber's DOB

Subscriber's SSN	Subscriber's Employer	Subscriber's Relationship to Patient

Who is responsible for the bill?

☐ Self ☐ Other: Name: _____	Relationship to Pt: _____
☐ Address Same as Above	Address: _____

Interested in following services (check box): ☐ Behavioral Health Center (The 7 Challenges Program)	

Are you satisfied with your current primary care? ☐YES ☐NO	**How did you hear about us?**	**Family Members Currently Enrolled?**

Currently Receiving services with (check box, if applicable): ☐ Family Health Center ☐ Behavioral Health Center	Received services in **Past** with (check box, if applicable): ☐ Family Health Center ☐ Behavioral Health Center

Therapist: Last Seen (date):	**Prescriber:** Last Seen (date):	**PCP:** Last Seen (date):

Internal Use: Appointment Date: _____ With: _____ Insurance Verified yes / no Staff: _____

Original Date: 6/15/17; Last Revision: 8/17, 11/17, 2/18, 2/19