SEVEN CHALLENGES REFERRAL

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

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