REFERRAL SOURCE			
AGENCY		PHONE	
LOCATION		EMAIL	

FORM COMPLETED BY		PHONE		DATE	

RECEIVING AGENCY				
AGENCY	Prism Counseling & Advocacy	PHONE | FAX	518.801.2521	518.665.3096
LOCATION	10 Colvin Ave Ste. 106 Albany, NY 12206	EMAIL	contact@prismalbany.org	

CLIENT INFORMATION				
LAST NAME		FIRST NAME LEGAL | CHOSEN		
DATE OF BIRTH		ASSIGNED SEX AT BIRTH | GENDER IDENTITY		
PRONOUNS		RACE | ETHNICITY		
INTERPRETER REQUIRED?		LANGUAGE REQUIRED		
GUARDIAN NAME		GUARDIAN RELATIONSHIP		
CLIENT'S ADDRESS		CELL PHONE		
		HOME PHONE		
		WORK PHONE		
		EMAIL		

PRESENTING CONCERNS / COMMENTS Attach additional sheets and / or supporting documentation as deemed necessary.	
REASON FOR REFERRAL	
PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.	
SERVICE / SPECIALTY REQUESTED	
ADDITIONAL COMMENTS	

INSURANCE INFORMATION									
AUTHORIZATION REQUIRED?		YES		NO	AUTH #		# OF VISITS		AUTH EXP. DATE
	PPO		HMO		OTHER	INSURANCE PLAN			
INSURANCE ID		PHONE #		OOP RATE					
INSURANCE HOLDER'S NAME		RELATIONSHIP TO PATIENT		DOB					

FORM RECEIVED BY		PHONE		DATE	