

SBH Referral/Consultation Request Form

**Please complete this form and fax to: (718) 690-3391**

For questions, call (718) 960-9122 or email cpro@sbhny.org

Date of Request: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Contact Number: ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_­

Address: City: State: Zip: ­­­\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Gender: 🗖 Male 🗖 Female 🗖 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Language: 🗖English 🗖Spanish 🗖 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Information**

Referring Provider (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP: 🗖Yes 🗖No

NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number**:** ( ) \_\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number: ( ) \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Consultation Request**

Diagnostic Test or Specialty Service Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

R/O or Reason for Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax relevant lab, imaging & other studies along with your referral.**

**CONFIDENTIAL COMMUNICATION**: **THIS TRANSMISSION IS INTENDED ONLY FOR THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED AND CONTAINS INFORMATION THAT IS CONFIDENTIAL. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE DESTROY THE FAXED MATERIALS AND CONTACT**

**THE SENDER IMMEDIATELY AT (718) 960-6659. THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RECORDS AND IS PROTECTED BY FEDERAL AND STATE LAW. THIS INFORMATION MAY INCLUDE CONFIDENTIAL MENTAL HEALTH, SUBSTANCE ABUSE, ALCOHOL ABUSE AND/OR HIV-RELATED INFORMATION.  FEDERAL AND STATE LAW PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC**

**WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY LAW.  ANY UNAUTHORIZED FURTHER DISCLOSURE IN**

**VIOLATION OF THE LAW MAY RESULT IN A FINE OR JAIL SENTENCE OR BOTH. A GENERAL AUTHORIZATION FOR THE RELEASE OF THIS INFORMATION MAY**

**NOT BE SUFFICIENT AUTHORIZATION FOR FURTHER DISCLOSURE.**

Please provide authorizations required. **SBH NPI: 1548367873**

Authorization Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of visits authorized, if applicable: \_\_\_\_\_\_\_\_\_\_\_ ICD – Code: \_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_