Department of Rehabilitation
Psychology & Neuropsychology
785 Mamaroneck Avenue
Billings Building, First Floor
White Plains, NY 10605
Phone: 914-597-2331
Fax: 914-597-2794

Outpatient Psychotherapy Referral Form
(Individual & Group)

Please fill out all information to facilitate the referral process.
To be faxed to 914-597-2794

Patient Information:

Name: _____ MRN# (if applicable): _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F _____ Primary Language: English Spanish Other: _____

Address: _____

Primary Phone#: _____-_____-_____ Email: _____

Emergency Contact: _____ Phone#: _____-_____-_____ Email: _____

Physician: _____ Phone#: _____-_____-_____

Referrer:

Requested by: _____Requested Date: _____/_____/_____

Phone: _____-_____-_____ Fax: _____-_____-_____

Pertinent medical history (include onset date) _____

_____

_____

_____

Medications _____

_____

Insurance Information: Please complete and include insurance card copy (back and front) to expedite referral (if external).

1. Insurer: _____ Ins ID#:_____ Grp#:_____

Policy holder's name: _____ SSN: _____-_____-_____

Date of Birth: _____/_____/_____ Phone: _____-_____-_____

2. Secondary Insurance: Yes No

If yes, Insurer: _____ Ins ID#:_____ Grp#:_____