Lakeview Health Services
Achieving goals. Advancing lives.

Children and Youth Outreach Referral Form
Lakeview Health Services
609 West Washington St., Geneva, NY 14456
Phone: (315) 789-0550 Fax: (315) 789-0555

Please note: Outreach referrals must be completed to the best of your knowledge, to be accepted by the Program Manager. This program serves ages 5-18.

Date: _____ **Medicaid CIN/Insurance:** _____ **County: Seneca** ☐ **Ontario** ☐

Client Name: _____ **DOB**: _____ **SS#**: _____

Parent/Guardian/Care giver: _____ **Phone:** _____

Address: _____

Referral source name & contact information: _____

Reason for referral: _____

Diagnosis: _____

Additional medical information (allergies, physical conditions, etc.): _____

_____

Current School and District: _____ **IEP or 504 Plan?** _____

Service providers/Supports already in place (PINS/probation, therapist/counselor, other agencies etc.): _____

Home environment (type of dwelling, number of people in household, pets etc.):

_____

Please list any safety/behavioral concerns: _____

_____