Lakeview Health Services
Achieving goals. Advancing lives.

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

Outreach referrals must be completed to the best of your knowledge, in order to be accepted by the outreach worker. Please include a copy of the most recent clinical information or a diagnostic impression that has been approved by a psychiatrist, if available.

Date: _____

Client Name: _____ DOB: _____ SS#: _____

Address: _____ Phone: _____

Insurance Information, if available: _____

Referral Source Name: _____

Contact Information: _____

Reason for Referral: _____

Diagnosis: _____

Is client currently in mental health treatment? _____ Provider Name: _____

Service Providers/Supports Already in Place: _____

_____

Does the individual have any needs related to substance abuse? _____

Medical issues including allergies: _____

_____

Current criminal justice status: _____

Probation/Parole Office name: _____ Phone #: _____

Please list any safety concerns: _____

_____