UNIVERSAL COMMUNITY REFERRAL & ELIGIBILITY APPLICATION
FORM OUTPATIENT /DAY HOSPITAL

INSTRUCTIONS: Please complete this form in its entirety to make a referral to Blythedale Outpatient and/or Day programs. *Please attach- prescription for" Evaluation & Treatment" (for recommended discipline OT, PT, ST, FT) to include ICD Diagnosis code.*			
Today's date:			
Referral Organization:		Name of Person Making the Referral:	
Referral Source Type:	☐*Hospital* ☐*Pediatrician* ☐*School* ☐*Caseworker* ☐*Specialist* ☐*Parent* ☐*Therapist* ☐*Other*	Phone: Email:	
Patient Name: **(Last, First, MI)** *(Include any alias, nicknames or other names the child/youth may be known by)*:			Date of Birth:
Home Address:			
City:	Zip:		County of Residence:
Gender: □ Male □Female □ Non Binary		Language Preference Other Than English: (Including ASL)	
Diagnoses:			
Primary Insurance Provider:		Policy #	
Name of Policy Holder		Policy Holder DOB:	
Phone # for Insurance Provider		Policy Holder's Employer:	
Secondary Insurance Provider:		Policy #	
Name of Policy Holder	Policy Holder DOB:		
Phone # for Insurance Provider	Policy Holder's Employer:	Email:	
Medicaid CIN#	Medicaid Plan Name:		
Other Insurance			
Parent/Guardian Name (s): **(Last, First, MI)**	Phone(s):	Email(s):	
Address if different:			
Reason For Referral:			
Outpatient □ Physiatrist □ Audiology □ Feeding Therapy □ Speech Therapy □ Physical Therapy □ Occupational Therapy	**Equipment/Assistive Technology** □Seating/Mobility □Augmentative Communication □Computer/environmental access □ Other	**Day Hospital Programs** □ Therapy w/onsite public school □ CPSE program □ Medical Preschool Program □ Specialized Programs (LE,UE,Feed)	
PERMISSION TO REFER: *You must identify that consent to refer has been obtained and who has given consent to refer. Please note that this can be a verbal consent received.*			
Consenter Name		Consent Date:	
Consenter Relationship:		Consenter Contact Info:	

Return to: DHOPDreferral@blythedale.org
Phone: 914-831-2458
Fax: 866-362-4721