THE KELBERMAN CENTER
AUTISM SERVICES ACROSS THE LIFESPAN
AN AFFILIATE OF UPSTATE CARING PARTNERS

KELBERMAN CENTER CLINIC REFERRAL/REQUEST FORM

To make a referral or to request an evaluation, or psychotherapy intake for yourself or your child, please complete the information below. You may fax this form to (315) 749-7054 or email to Clinic@Kelbermancenter.org

Date Completed:		**Referral Source:** ☐Parent ☐School ☐Physician ☐MSC ☐Other		
Patient Name:		Referral Contact Name:		
Date of Birth:		Referral Phone No:		
Guardian:		Has referral been discussed with client (or guardian if a minor)?		☐Yes ☐No
Medicaid Service Coordinator MSC:		Proof of Negative TB test within the past year?		☐Yes ☐No
Mailing Address:		Client (or Guardian) Phone No:		
		Client SS #:		
Medicaid / Medicare #:		Current/ Prior Diagnoses:		
Other Insurance:		Policy Number:		

Desired services:

☐ Counseling assessment/ Psychotherapy
*Article 16 Counseling requires proof of negative TB results

☐ Psychological Evaluation
(☐ Autism, ☐ OPWDD Eligibility etc. ☐ Other
☐ Learning Disability/ Educational Recommendations
☐ Guardianship)

Reason for Referral / Desired Outcome of Intake or Treatment (please describe):

Current Concerns:

Person Completing Form:	Relationship to Patient: