Long Island
Select Healthcare

Phone: 631-650-2510

New Patient Behavioral Health Checklist

Behavioral Health services require a referral from a PCP prior to scheduling. To expedite scheduling please provide a referral from your PCP with this packet.

If you do not have a current PCP, please let us know.

____ Physician Referral or Script clearly stating medical necessity on request, including ICD-10 code.

____ Copies of Previous Psychiatric Evaluation and/or Psychological Testing

☐ *Not Applicable*

____ Copy of your most recent physical examination for review and medical records purposes.

____ Copy of Legal Guardian documentation for medical records.
*If the patient has a court appointed Legal Guardian, a copy of this legal form is necessary for his/her chart at LISH before an appointment can be scheduled. Please attach it to this application.
☐ *Not Applicable*

An Introductory Intake Appointment will be scheduled for the following services:

- **Behavioral Health Counseling**
- **Psychological Testing**
- **Neuropsychological Testing**
- **Psychiatric Services and/or Medication Management**

*Please note - If you are requesting an evaluation for legal purposes (e.g. court-appointed, to obtain guardianship papers, or requested by a school district) these services are not considered medically necessary and will not be covered by your health insurance company. Evaluations for legal purposes will be considered self-pay.

**Long Island Select Healthcare is a full-service Federally Qualified Health Center (FQHC) with eight locations throughout Suffolk County. In addition to mental health services we offer Primary Care, GYN, Neurology, Podiatry, Allergy, Dermatology, Endocrinology, Dental, Audiology, and Optometry. We also provide Physical Therapy, Occupational Therapy, and Speech Therapy to patients with developmental disabilities. If you are interested in additional services, please let us know.

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Patient Name:_____ Date of Birth:_____

Behavioral Health Services Packet

What services are you seeking? Select all that apply.

___ **Psychiatric or Psychological Evaluation** – An introductory appointment used to gather information about the patient, determine needs, and refer for additional services.

___ **Psychosocial Evaluation –** An appointment used to gather information about a person's family history, work history, and other social factors often used by various state agencies.

___ **Psychological Testing –** A series of tests which may include IQ Testing, Adaptive Assessments, Aptitude testing, or more designed to evaluate general cognitive and personality functioning. Used to diagnose psychiatric conditions.

___ **Neuropsychological Testing** – An extensive set of specific tests designed to evaluate cognitive strengths and weaknesses. These tests help healthcare providers gather a better understanding of the patient's brain functioning.

___ **Behavioral Health Counseling –** Regular appointments designed to help individuals talk through issues, determine the underlying causes for certain behaviors, and manage those behaviors.

___ **Medication Management –** Ongoing appointments used to monitor psychiatric medication and treatment plans to determine the best course of action to improve an individual's mental health.

Have you had any of the following evaluations within the Past 5 Years?
(Mark all that apply)

****If yes, please provide copies of reports.**

___ Psychosocial ___ Psychological ___ Neurological ___Neuropsychological

___ Neuropsychiatry ___ Psychiatric ___ Developmental ___ Educational ___ Genetic

Dates of past evaluations: _____

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Patient Name:_____ Date of Birth:_____

Patient's Name:_____ DOB: _____

Legal Guardian:_____ Phone: _____

Street Address: _____

City:_____ State:_____ Zip: _____

Telephone - Home:_____ Cell:_____ Other: _____

Emergency Contact - Name:_____Phone:_____

Caseworker/Service Coord & Agency Name:_____

Phone:_____ Fax: _____

Primary Insurance Carrier: _____ ID#: _____

Secondary Insurance Carrier: _____ ID#: _____

Tertiary Insurance Carrier: _____ ID#: _____

Reason for seeking treatment: _____

Is this a court appointed evaluation? Select one (YES) ___ (NO) ___

If yes, what is the reason? _____

Do you have a referral from your PCP? Select one (YES)___ (NO)___

If yes, please provide the name and phone number of your PCP:

PCP Name: _____ Phone Number: _____

Have you had a recent physical exam by your PCP? Select one (YES)__ (NO)__

Date of your last physical exam: _____

Does the patient have a developmental disability? Select one (YES)___ (NO) ___

If yes, what is the patient's diagnosis?

_____

_____

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Patient Name:_____ Date of Birth:_____

Please List All Current Medications.

Medication	Dosage	Frequency

Person Completing This Form

Name: _____ Relationship: _____

Phone number: _____

Please return completed forms to:
Long Island Select Healthcare, Inc.
Attn: Patient Navigator
159 Carleton Ave.
Central Islip, NY 11722-4172