REFERRAL FORM
WASHINGTON HEIGHTS COMMUNITY SERVICES
AUDUBON CLINIC
513 West 166th Street, New York, NY 10032
***Referral Email**: Audubonclinicreferrals@nyspi.columbia.edu*
Referral Inquiries: 212-928-8178
Fax: 212-905-9246

Date of Referral:

Patient Information:

First and Last Name:

Date of Birth: Insurance:
Address:

Phone Number: Language(s) Spoken:
Email:

Has the patient received psychiatric services at another clinic during the past year? If so, when and where:

Does the patient have any DSM-5 Diagnosis(es)? If yes, which one(s)?

Is the patient currently prescribed psychiatric medication(s)? If yes, which one(s)?

Does the patient have current/past history of violence, self-harm/suicidality, or criminal charges?

Does the patient have current/past history of substance use?

Does the patient experience any mobility issues?

Referring Clinician and Agency Information:

Agency Name:

Clinician's First and Last name:

Clinician's email:

Clinician's phone number:

Please email or fax completed form along with supporting documentation (such as recent psych eval, med list, discharge paperwork, AOT order) to the email/fax listed above.
Referral acceptance is subject to review of materials by the intake coordinator.