

# HORIZONS ARTICLE 16 CLINIC

A Division of Arc of Onondaga  
600 South Wilbur Avenue  
Syracuse, New York 13204  
(P): (315) 476-7441 (F) 476-1582  
**Request for Additional Services**

Consumer Name: \_\_\_\_\_ Date of request: \_\_\_\_\_

Address (City/Street/Zip): \_\_\_\_\_

Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_

**Name of Person Making Request:** (Please indicate name, agency, address/phone number). **Also, if consumer has a Legal Guardian, the Guardian *must* be notified of the referral being made by the referring source.**

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### Service(s) Requested

Psychological Assessment (IQ):  Psychological Assessment (Adaptive Testing):  Sexuality Assessment:

Guardianship/Medical Affidavits:  Psychological/Social Work Counseling:  Nursing Services:

Nutritional Counseling Services:  Rehabilitation (Vocational) Counseling:   
(include prescription if doctor ordered)

**\*OT and PT Services available for the following Arc Day Programs only (please indicate program)**

Galeville  Lakeshore  Salina  Fremont  Hampton

Physical Therapy  Occupational Therapy

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### **Specify needs to be addressed:**

\_\_\_\_\_  
\_\_\_\_\_

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**\*\*\* Is the consumer currently receiving any other Article 16 Clinic Services?** (ie. Psychiatry, Psychology, Social Work, Rehabilitation Counseling, Nursing, Nutrition, Occupational, Aquatic, or Physical Therapy? Yes  No

**\*\*\*If so, when scheduling an on-going appointments with Horizon's Article 16 clinic, the appointment at our clinic **must** occur on a different day than the appointment at the other Article 16 Clinic.**

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Treatment Coordinator Additional Notes/Information: \_\_\_\_\_

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**I have reviewed all of the medical documents requested and forwarded to this Clinic related to the care of this consumer and give my approval for the above listed service(s).**

Approval Signature of Physician: \_\_\_\_\_ M.D. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Clinic Treatment Coordinator: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_