Adult Outpatient Mental Health Services
Information for Agencies, Patients and Families

Adult Outpatient Mental Health Services at Ellis Medicine currently serve Schenectady County residents who have Medicaid (including Managed Care: CDPHP and Fidelis), Medicare, and those without insurance/eligible for Charity Care. Our programs serve adults, 18 years of age or older, with a mental illness. Our Mental Health Clinic and PROS programs provide safe care by highly trained therapeutic teams of psychiatrists, social workers, psychiatric nurses, and licensed mental health counselors. The following is a list of common mental illnesses that are treated: Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Post-Traumatic Stress Disorder (PTSD) and co-occurring alcohol and chemical dependency issues.

MENTAL HEALTH CLINIC
The Ellis Medicine Mental Health Clinic is an outpatient program that provides counseling and medication management to adults. Therapeutic groups are also offered with a specialization in Trauma Recovery and Dual Disorder Treatment. Outpatient participants may attend 1-2 groups weekly depending on their needs. Focus of treatment is living safely and productively in the community.

PROS
Ellis Medicine Personalized Recovery Oriented Services (PROS) is a comprehensive mental health service that offers rehabilitation, support, and treatment services under one roof. The program offers an array of educational and skill acquisition groups geared to help consumers achieve their chosen recovery goals in the areas of work, education, relationships and living environment. The purpose of PROS is to help people take control of their lives by teaching the skills and abilities necessary to overcome barriers and effectively negotiate the challenges they face. These services offer hope and assistance to individuals in regaining life roles that have been lost or never achieved due to mental illness. There are specific groups integrating treatment for dual disorders and for people recovering from the effects of trauma. The program also provides individual therapy and medication management as needed. Social and recreational activities are also offered to program participants.

For new referrals to the Mental Health Clinic and PROS please fax the following:
Referral form, release of information, assessments, medication lists, and progress notes to
(518) 377-9151 Attn: Intake

Referring agencies should have the applicant call our Intake Specialist directly at (518) 831-6946 after the records and referral sheet have been faxed.

If you are interested in services for anyone below the age of 18, please contact the program below:
Child and Adolescent Outpatient Mental Health Clinic (518) 382-2290 Fax: (518) 382-2292

FAMILY SUPPORT GROUP
A weekly group held at Ellis Hospital that provides support and education to adult family members and friends of those afflicted with mental illness. Please contact Kevin Moran at 243-4255 for more information.

CRISIS
Ellis Medicine Crisis Services are provided to individuals experiencing a psychiatric emergency in need of safety and stabilization. The team of crisis mental health professionals provide confidential mental health assessments for individuals in psychiatric crisis. Assessments are conducted at the Ellis Medicine Emergency Room, 1101 Nott Street, Schenectady; 24 hours a day, 7 days a week. Staff also provides assistance and support over the telephone 24 hours a day, 7 days a week for the Schenectady County community on our Crisis Hotline at (518) 243-4000 or (518) 243-3300.

If you or a loved one are experiencing a psychiatric emergency please call 911 or go to the nearest Emergency Room for an evaluation.
Date: ________________

Care Central patient? ☐ No ☐ Yes

Patient Name (last, first): ____________________________ Alternative Name: ____________________________

DOB: _____/_____/_______ SSN#: __________-____-_____

Address: ______________________________________ Apt #: ______ Gender: ☐ Male ☐ Female ☐ ______

City: __________________________ State: ______ Zip:_________

Phone # (____) _______ - ______ Alternate #: (____) _______ - ______

Primary Language: ☐ English ☐ Spanish ☐ Other: __________________________

Insurance (check all that apply): ☐ None ☐ Charity Care ☐ Charity Care Pending ☐ Medicaid Pending
 ☐ MEDICAID # ___________________ (circle one) CDPHP/Fidelis ☐ MEDICARE # __________________________
 ☐ OTHER ______________________ ID#: __________________________ GROUP #: __________________

Veteran or VA eligible? ☐ Yes ☐ No Receives Social Security? ☐ Yes ☐ No If Yes circle: SSI SSDI

Released from Schenectady County Correctional Facility in the past 30 days? ☐ Yes ☐ No

Referral by: Name: ____________________________ Phone: (____) _______ - _______ ext _______

Agency: ____________________________ Fax: (____) _______ - ______

Program referred to (descriptions on Page 1): ☐ PROS ☐ Mental Health Clinic

Reason referring to mental health treatment: __________________________________________________________________________________________
________________________________________________________________________________________

Has your patient received psychiatric services in the past? ☐ No ☐ Yes
If Yes, where/when: __________________________________________

Was your patient ever in outpatient or inpatient addiction treatment? ☐ No ☐ Yes
If Yes, where/when (include outcome): __________________________________________

Does your patient have history of alcohol or substance abuse? ☐ No ☐ Yes If Yes, what: _______________________________________________________________________

Last use of alcohol? ________ ☐ Days ☐ Weeks ☐ Months ☐ Years Amount: __________________________

Last use of other drugs? ________ ☐ Days ☐ Weeks ☐ Months ☐ Years Amount: __________________________

Is your patient currently in treatment with a mental health or addiction provider? ☐ No ☐ Yes
If Yes, where (referral from current provider required): ____________________________________________________________________________

Is your patient currently on any medications? ☐ No ☐ Yes If Yes, please have current physician continue medications.

Current medications (include who is prescribing and date will run out): ____________________________

Name of Primary Care Physician: __________________________ Practice Name & Phone Number: __________________________

Please list information about any history of suicidal thoughts/attempts, self-mutilation (i.e. cutting, burning), and thoughts of harm or actual harm to others: ____________________________________________________________________________

Does your patient have interest in receiving assistance in the following areas? (Check all that apply.)

☐ Living Situation ☐ Employment ☐ Education ☐ Relationships

Is your patient willing to attend a group based program multiple times per week? ☐ No ☐ Yes

Records should be sent with this referral form. Please fax to (518) 831-6900 Attn: Intake