Saint Vincent's SERVICES

2425 Highland Avenue
Fall River, MA 02720
Ph.508-679-8511 Fax 508-672-2558

Referral for CBHI Services

Therapeutic Mentoring ☐ **In Home Therapy** ☐

Date of Referral: _____

Youth's Name: _____ DOB: _____ Age: _____

Gender: _____

Parent/Caretaker Name(s): _____
Street Address: _____
City,State, Zip Code: _____
Phone: _____Work Phone: _____Cell Phone: _____
Best time to contact family: _____

Is family/guardian aware and in agreement with referral? Yes☐ No☐
Has family been informed about what the service offers? Yes☐ No☐
Who has authority to sign consents? _____

Referred by: _____ Care Coordinator/Hub Provider: _____
Agency: _____ Agency: _____
Phone: _____ Phone: _____
Email: _____ Email: _____

Reason for referral:

Has the referred youth (or his/her family) experienced a traumatic event(s):
Yes☐ No☐
If yes, describe:

Insurance Information

MassHealth #: _____
MCE coverage: _____

Medication: _____
Ethnicity: _____ Primary Language: _____
Religious Affiliation: _____

Axis Diagnosis:

Axis I:
Primary:
Secondary:
Axis II:
Axis III:
Axis IV:
Axis V:

With whom does the youth currently reside?

Is the youth and/or family involved with any state agencies? Yes □ No □
(DCF, DMH, DYS, DDS, legal involvement)
If Yes, please list names and contact information)

Goal(s) of service(s) to be provided?

To be included with referral:
□ Copy of care plan/treatment plan
□ Copy of CANS
□ Risk Management/Safety Plan (TM and CSA clients)
□ Comprehensive Assessment/Mental Status (TM only)

Other Information:

_____ _____
Signature of Referral Source **Date**

Fax completed referral form and all appropriate documentation to:

Allison Garside, LICSW
Intake Coordinator
Saint Vincent's Services
Fax: 508-672-2558
Ph.: 508-235-3425