Saint Vincent's SERVICES

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

Referral for Mental Health Clinic Services

Individual Therapy ☐
Family Therapy ☐

Medication Management/Psychiatry ☐
**Medication Management/Psychiatry services can only be received in conjunction with a therapy modality.*

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: _____
Who has authority to sign consents? _____

Is family/guardian aware and in agreement with referral? Yes☐ No☐
Has family been informed about what the service offers? Yes☐ No☐

Referred by: _____
Agency: _____ Phone: _____
Email: _____

Reason for referral:

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

Insurance Information

For Commercial Insurance and HMO's:
Type of Insurance: _____
Insurance Number: _____
Responsible Party: _____
please attach a copy of the insurance card

For MassHealth Clients:
MassHealth #: _____
MCE coverage: _____
please attach a copy of the insurance card

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?

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