Metrowest Behavioral Health Center

Referral – Outpatient Therapy

Date of Referral: _____

When complete, please email to MBHCintake@jri.org.

Information about Person Being Referred:

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Other:** _____

Name: _____ **D.O.B:** _____

Address: _____ **Telephone (home/cell/work):** _____

Email Address: _____

Primary Insurance: _____ **Policy #:** _____

Secondary Insurance: _____ **Policy #:** _____

Social Security #: _____

Racial ID (all that apply):
☐ American Indian, Alaskan Native, or Indigenous North American ☐ Asian or Asian American
☐ Black or African American ☐ Latino/a/x or Hispanic ☐ Native Hawaiian or other Pacific Islander
☐ White or European American ☐ Multiracial ☐ Declined to Specify
☐ Racial ID not listed, please specify:

Ethnic ID: ☐ Latino/a/x or Hispanic ☐ Not Latino/a/x or Hispanic ☐ Declined to Specify

Gender ID (all that apply):
☐ Cisgender Woman/Girl ☐ Genderfluid ☐ Genderqueer ☐ Cisgender Man/Boy ☐ Non-Binary
☐ Transgender Man/Boy ☐ Transgender Woman/Girl ☐ Declined to Specify
☐ ID not listed, please specify:

Pronouns: _____

Best Times to Call/Scheduling Needs: _____

Name and Address of PCP: _____

Allergies/Medical Conditions/Medications:

Emergency Contact Name, Phone Number, and Relationship to Client:

Parent/Guardian Information (☐ ***Check here if person is adult/own guardian and skip to next section)*:**

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Other:** _____

Name: _____ **Relationship to Child:** _____

Address: _____ **Home Telephone:** _____

Cell Phone: _____ **Other Telephone:** _____

Legal Guardian (☐ same as above): _____

Physical Custody: (☐ same as above): _____

Where does child currently live? ☐ With Parent(s)/Guardian(s) ☐ Foster Home ☐ Group Home ☐ Other:

If not with parent(s)/guardian(s) listed above, please give name, address, and telephone number of current residence:

What School Does Youth Attend:

Additional Identifiers

Does client identify as (select all that apply): ☐ Deaf/Hard of Hearing ☐ Currently or recently unhoused or experiencing housing instability ☐ LGBTQ+ ☐ Immigrant/Refugee/Asylum-seeking ☐ Veteran ☐ Having limited use of English

Does client identify as disabled/having a disability? ☐ Yes ☐ No ☐ Declined or unknown

If yes:

Nature of disabilit(ies): ☐ Cognitive ☐ Physical ☐ Mental/Psychological ☐ Not listed, please specify:

Currently on SSI/SSDI? If so, date when started? _____

Has this client been the victim of a crime?* ☐ Yes ☐ No ☐ Unknown or Declined

*"Crime" refers to any experience that is legally considered criminal (e.g., physical or sexual violence, parental abuse or neglect, bullying, stalking, etc.). It is not required that the crime was ever reported.

Person Making Referral: *(☐Check here if self-referral)*:

Name and Role: _____

Fax: _____ **Organization:** _____

Address: _____ **Work Phone:** _____

E-mail: _____ **Cell Phone:** _____

Referral Source Type: ☐ CBAT/TCU ☐ CSA ☐ DCF ☐ DYS ☐ Family/Youth ☐ Hospital ☐ In-Home Services ☐ MCI ☐ Outpatient ☐ PCP ☐ School ☐ Other:

Known Services/Agency Involvement:

	Past	Current	Unknown	Contact Person and Telephone and/or e-mail
☐ Department of Children and Families (DCF)	☐	☐	☐	
☐ Department of Mental Health (DMH)	☐	☐	☐	
☐ Department of Youth Services (DYS)	☐	☐	☐	
☐ Child Requiring Assistance (CRA)/Court	☐	☐	☐	
☐ In Home Therapy/Family Stabilization Team	☐	☐	☐	
☐ Therapeutic Mentoring/Other Mentoring	☐	☐	☐	
☐ In-Home Behavioral Services	☐	☐	☐	
☐ Therapy/Counseling/Outpatient Services	☐	☐	☐	
☐ Psychopharmacology/Psychiatry Services	☐	☐	☐	
☐ Hospitalized	☐	☐	☐	
☐ ER visit or screened in last 6 months	☐	☐	☐	
☐ Not listed, specify:	☐	☐	☐	

Service Preferences: *(Please note: we will accomodate based on clinical appropriateness and program capacity)*

Best Times/Days to be Seen:

Preferred Place(s) to be Seen: ☐ MBHC Office ☐ School ☐ Home ☐ Telehealth ☐ Other:

Service(s) Requested: ☐ Individual Therapy ☐ Family Therapy ☐ Couples Therapy ☐ Group Therapy

Brief description of your concerns and goals in referring this person *(please include any current safety concerns)*:

Thank you for taking the time to complete this form! A clinical staff member will be in touch with next steps.