CHILDREN'S FRIEND & FAMILY SERVICES
A DIVISION OF JRI

Referral – Outpatient Therapy

Date of Referral: _____

☐ **Salem:** 110 Boston St, Salem p: 978.744.7905 **Please fax to: 978.740.9145**	☐ **Lynn:** 112 Market Street, 2nd Fl,Lynn p: 781.593.7676 **Please fax to: 781.595.1081**
☐ **Gloucester:** 33 Commercial St, Gloucester p: 978.283.7198 **Please fax to: 978.281.7793**	☐ **Lawrence:** 15 Union St, Ste. 200, Lawrence p: 978.682.7289 **Please fax to: 978.686.2954**

Person Being Referred Information:

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

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

School: _____ **Grade:** _____ **IEP?** ☐Yes ☐No

Primary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** _____

Secondary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic, Latino, or Spanish Origin ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Declined to Specify ☐ Other Race:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify **SS#:** _____

Gender: ☐Declined to Specify ☐Female ☐Gender Fluid ☐Gender Queer ☐ Male ☐Non-Binary ☐Other/Non-conforming ☐Trangender Man ☐Transgender Woman

Psychiatric Diagnosis*: **DSM Code:** _____ **Narrative:** _____

DSM Code: _____ **Narrative:** _____

***Who generated dx and when?** _____ _____

****Including this information significantly assists in ability to gain authorization for service. Please include when at all possible.***

PCP: _____

Allergies/Medical Conditions/Medications:

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:** _____

Best Times to Call/Scheduling Needs: _____

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:

Emergency Contact Information (please identify a secondary person to contact if parent/guardian is not able to be reached):

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

Name: **Relationship to Child:**

Cell Phone: **Home Telephone:**

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Person Making 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	☐	☐	☐	
☐ Other:	☐	☐	☐	

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

Best Times/Days to be Seen:

Preferred Place(s) to be Seen: ☐ Children's Friend Office ☐ School ☐ Home ☐ Other:

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

The following evidence-based treatments are offered at CFFS. Please check if you would like us to explore the use of one of these models with the person being referred:

☐ **Trauma Focused Cognitive Behavioral Therapy (TF-CBT):**

TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

☐ **Positive Parenting Program (Triple P):**

Triple P is one of the most effective evidence-based parenting programs in the world, backed up by more than 30 years of ongoing research. Triple P gives parents simple and practical strategies to help them confidently manage their children's behavior, prevent problems from developing and build strong, healthy relationships.

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

Risk Factors: ☐DV ☐Mental Illness ☐Substance Use ☐Abuse ☐Neglect ☐Medical Issues ☐Cultural Factors ☐Suicidal/Homicidal Ideation ☐ Other: