



Leader in Social Justice

Date of Referral: _____

Metrowest Behavioral Health Clinic and Community Based Services

360 Massachusetts Ave, Acton, MA 01720 Phone (978) 263-3427 / Fax (978) 263-3498

PLEASE ENSURE person/parent/guardian/caregiver voluntarily agrees to this service and referral

Once completed, please EMAIL referral to mbhcintake@jri.org	All ages:		Youth Up to Age 21 (Eligibility based on Insurance plan coverage):		
	Outpatient	Outpatient Groups	In Home Therapy	In Home Behavioral Service	Therapeutic Mentoring*
Please select the service being referred to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Therapeutic Mentoring referral must come from Outpatient Therapist, IHT, or ICC and include attached Comprehensive Assessment, CANS and Treatment/Individualized Action/Care Plan

Person Being Referred Information:

Preferred Name:

Preferred Language: English Spanish Other: _____

Legal Name: _____ D.O.B: _____

Address: _____ Home Telephone: _____

Cell Phone: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Preferred Pronouns: _____ Email: _____

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

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

Gender: Cisgender Woman/Girl Cisgender Man/Boy Genderfluid Genderqueer Non-Binary
 Transgender Man/Boy Transgender Woman/Girl Declined to specify Not listed, please specify: _____

PCP: _____

Allergies/Medical Conditions/Medications: _____

Best Times to Call/Scheduling Needs: _____ Can leave messages on Home phone? Cell phone?

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: _____

What school & grade does youth attend: _____

Is youth on a 504 Plan / IEP?: _____

Person Making Referral: (Check here if self-referral) (Check here if parent/caregiver is aware of referral)

Name and Role: _____	
Fax: _____	Organization: _____
Address: _____	Work Phone: _____
E-mail: _____	Cell Phone: _____

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

Best Times/Days to be Seen: _____
Preferred Place(s) to be Seen: <input type="checkbox"/> Office <input type="checkbox"/> School <input type="checkbox"/> Home <input type="checkbox"/> Telehealth <input type="checkbox"/> Other:

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

Known Services/Agency Involvement:

	Current	Closed within past 30 days	History	Contact Person and Telephone and/or e-mail
<input type="checkbox"/> Department of Children and Families (DCF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Department of Mental Health (DMH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Department of Youth Services (DYS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Child Requiring Assistance (CRA)/Court	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> In Home Therapy/Family Stabilization Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Therapeutic Mentoring/Other Mentoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> In-Home Behavioral Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Therapy/Counseling/Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Psychopharmacology/Psychiatry Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> ER visit or screened in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

History of Psychiatric Diagnosis:

Please list any known diagnosis (required for TM/FST referrals):
Risk Factors: <input type="checkbox"/> DV <input type="checkbox"/> Mental Illness <input type="checkbox"/> Substance Use <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Medical Issues <input type="checkbox"/> Cultural Factors <input type="checkbox"/> Suicidal/Homicidal Ideation <input type="checkbox"/> Psychiatric ER visit or screened in last 6 months <input type="checkbox"/> History of Psychiatric hospitalization <input type="checkbox"/> Other:
Strengths:

Accepted insurances for JRI: (eligibility based on plan coverage)

Allways Health Partners My Care Family (Mass Health) • Allways Commerical • Beacon /Fallon (Commercial)
 Beacon/Boston Medical HealthNet Plan (Commercial) • Beacon/Boston Medical HealthNet Plan (Mass Health)
 Beacon/ Fallon (Mass Health) • Blue Cross Blue Shield of MASS • GIC Unicare (Commercial) • Harvard Pilgrim
 MBHP/Massachusetts Behavioral Health Partnership • Medicaid • Medicare • United Healthcare
 United Behavioral Health • Tufts Public Health Plan (Mass Health)