



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 <a href="mailto:mbhcintake@jri.org">mbhcintake@jri.org</a>	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)

<b>Name and Role:</b> _____	
<b>Fax:</b> _____	<b>Organization:</b> _____
<b>Address:</b> _____	<b>Work Phone:</b> _____
<b>E-mail:</b> _____	<b>Cell Phone:</b> _____

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

<b>Best Times/Days to be Seen:</b> _____
<b>Preferred Place(s) to be Seen:</b> <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:**

<b>Please list any known diagnosis (required for TM/FST referrals):</b>
<b>Risk Factors:</b> <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:
<b>Strengths:</b>

**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)