CHILDREN'S FRIEND & FAMILY SERVICES
A DIVISION OF JRI

Date of Referral: _____

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

Please select location and service preference(s):	All ages:		Youth Up to Age 21 (Eligibility based on Insurance plan coverage):				
	Outpatient	Outpatient Groups	In Home Therapy	In Home Behavioral Service	Community Service Agency	Family Support & Training*	Therapeutic Mentoring*
☐ Salem; Please fax: 978.740.9145	☐	☐	☐	-	-	-	☐
☐ Lynn; Please fax: 781.595.1081	☐	☐	☐	-	-	-	☐
☐ Gloucester; Please email Gloucester@jri.org	☐	☐	☐	☐	☐	☐	☐
☐ Lawrence; Please fax : 978.686.2954	☐	☐	☐	-	☐	☐	☐
☐ Chelmsford; 978.221.5831	-	-	☐	☐	-	-	☐

***TM & FS&T referral must come from Outpatient Therapist, IHT, ICC**

Attach: Comprehensive Assessment, CANS and Treatment/Individualized Action/Care Plan. **ICC:** ensure goal is entered into Provider Connect

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: ☐ Office ☐ School ☐ Home ☐ Telehealth ☐ 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
☐ 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:	☐	☐	☐	

History of Psychiatric Diagnosis:

Please list any known diagnosis (required for TM/FST referrals):

Risk Factors: ☐DV ☐Mental Illness ☐Substance Use ☐Abuse ☐Neglect ☐Medical Issues ☐Cultural Factors ☐Suicidal/Homicidal Ideation ☐ Psychiatric ER visit or screened in last 6 months ☐ History of Psychiatric hospitalization ☐ 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)