



Leader in
Social Justice

Southeast Behavioral Health Center
Program Director Andrea Joyner, LICSW
35 Summer St. Suite 202 Taunton, MA 02780
Office 508-828-1308
Fax 508-884-2476
Email: ajoyner@jri.org

Date of Referral

Please ensure person/parent/guardian/caregiver voluntarily agrees to this service and referral

Instructions:

- Please fill out this form as completely as possible.

This referral is for:

Outpatient (Individual)

Outpatient Family

Outpatient Groups

Preferred Language

Preferred Name

First Name

Last Name

D.O.B.

Address

Home Phone

Cell Phone

Primary Insurance

Policy #

Secondary Insurance

Policy #

Email

Racial Identity
(all that apply)

American Indian, Alaskan Indian 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 Not listed, please specify

Ethnic Identity

Latino/a/x or Hispanic Not Latino/a/x or Hispanic Declined to Specify

Gender Identity

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

PCP

Last Physical

Allergies/Medical Condition

Sexual Identity: Please Self Describe

Prefer not to say

Preferred Pronouns

Parent/Guardian Information ([check here if person is adult/own guardian and skip to next section](#))

Preferred Language

First Name

Last Name

Relationship to Child

Address

Home Phone

Cell Phone

Other Phone

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 does youth attend?

Grade

IEP/504

Person Making Referral ([check here if self-referred](#))

Name and Role	
Organization	Work Phone
Address	Cell Phone
Email	

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

Preferred contact and appointment times					
Preferred location for service	Office	School	Home	Telehealth	Other:
Accessibility Needs	Language or Communication Access Needs				
Brief description of your concerns and goals in referring this person (please include any current safety concerns):					

Known Services/Agency Involvement:

	Past	Current	Unknown	Contact Person and Telephone and/or email
Department of Children & 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				
ICC/FP				
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:					

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

Mass General Brigham Health Plan (Mass Health) • Mass General Brigham Health Plan Commercial • Wellsense/Carelon (Mass Health) • Wellsense/Carelon (Commercial) • Wellsense/Fallon (Mass Health) • Wellsense/Fallon Commercial • 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), and Tufts Commercial