Justice Resource Institute

Southeast Behavioral Health Center

Program Director Andrea Joyner, MSW, LICSW
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P# 508-828-1308 F# 508-884-2476

Instructions:

- Please fill out this form as completely as possible.
- Complete page 1-3 for **ALL** referral types- outpatient, TM, IHT, and psychiatry.
- If referral is for **TM** services you *must* also submit a treatment plan with TM goals and an updated CANS, if **not** included service will not open until submission is received.
- Once completed please fax Attn: Andrea Joyner at 508-884-2476.

This referral is for: (please check all that apply)

Psychiatry ☐		
In Home Therapy (IHT) ☐	Therapeutic Mentoring(TM) ☐	Outpatient(Group) ☐
Outpatient (Individual) ☐	Outpatient(Family) ☐	Equine Tx ☐

Date of referral:

Person's Name Identified Gender

DOB Age SSN

Address:

Phone: Alternate Phone:

Guardian's Name(s) Relationship to Person:

Ethnicity	Race
☐ Hispanic or Latino	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ Asian
☐ Declined to Specify	☐ Black or African America
	☐ Native Hawaiian or Other Pacific Islander
	☐ White
	☐ Declined to Specify

Does the person/guardian speak English? Preferred Language:

Primary Insurance: **Policy/ID #**

Secondary Insurance **Policy/ID #**
(if applicable)

Southeast Behavioral Health Center Referral page two

Referral Source Agency:

Referral Source Name: Phone:

Referral Source Role/ relationship to person:

☐ Outpatient therapist ☐ In Home therapist ☐ Intensive Care Coordinator

☐ Other:

List all family members (currently living in the home):

Name:	DOB:	Relationship to person:
Name:	DOB:	Relationship to person:
Name:	DOB:	Relationship to person:
Name:	DOB:	Relationship to person:
Name:	DOB:	Relationship to person:

Why is the person in need of services at this time?

What goals need to be addressed with services?

Current Diagnosis (please include name and codes)

Medications (please list name and dose)

Name of prescriber: Phone:

*Please fill in the following information if applicable.

DCF Contact Person:

Name Phone

DMH Contact Person:
Name Phone

Outpatient Therapist:
Name Phone

School System:
Contact(s) Phone