

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*
<input type="checkbox"/> Salem; Please fax: 978.740.9145	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-	-	<input type="checkbox"/>
<input type="checkbox"/> Lynn; Please fax: 781.595.1081	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gloucester; Please email Gloucester@jri.org	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-	-	<input type="checkbox"/>
<input type="checkbox"/> Lawrence; Please fax : 978.686.2954	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chelmsford; 978.221.5831	-	-	<input type="checkbox"/>	<input type="checkbox"/>	-	-	<input type="checkbox"/>

***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 Language: ☐ English ☐ Spanish ☐ Other: _____

Name: _____ D.O.B: _____

Address: _____ Home Telephone: _____

Cell Phone: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Social Security #: _____ 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: _____

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: _____ Email: _____

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 Does Youth Attend: _____

Person Making Referral: (☐ Check here if self-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:

	Past	Current	Unknown	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

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)