

MetroWest Community Based Services

### 360 Massachusetts Ave

**Acton, MA 01720**

**Phone (978) 263-3427 / Fax (978) 263-3498**

**INSTRUCTIONS:**

**Please fill out this referral form as completely as possible.**

For **In-Home Therapy (IHT), In-Home Behavioral Services (IHBS), or Therapeutic Mentoring (TM)** we accept the following insurances: MBHP, Tufts/Network Health, BMC Master Plan, Inc. BMC, Fallon & NHP

**IHBS** and **TM referrals** are made by a person’s Outpatient Therapist, IHT or ICC.

**IHBS** and **TM referrals** please fax a copy of the most recent CANS, Comprehensive Assessment, Safety Plan, and the person’s current Treatment plan/care plan with goals of treatment identified. Services cannot start until all paperwork is received.

**Once completed, please EMAIL referral to** **mbhcintake@jri.org** **Please note in email subject line if referral is for IHT, TM, or IHBS.**

Person’s Name: \_ Identified Gender:

\_\_\_\_\_\_\_\_\_

Other

DOB:

Age:

SSN:

Allergies:

Ethnicity: \_\_\_ \_ Race: \_ \_ \_

Address:

Zip: \_

Guardian Phone:

Person/Guardian Email:

Alt. Phone: (cell) \_

Guardian’s Name (s)

Relationship to Person: \_

Guardian’s Address (if different than client):

Does the person/guardian speak English?

Preferred Language:

Source of Referral: OPT IHT I.C.C. Parent Hospital Other:

Referring Agency:

Person making referral: Relationship to Person:

Phone: \_ Fax: \_ Email:\_

Has client received services here before? Y N Special Communication Needs?:

\_\_\_

\_\_\_

Emergency contact info (name, address, phone #):

|  |  |
| --- | --- |
| **Policyholder Insurance Company Name:** | **Policyholder Name:** |
| **Policy Number:** | **Policyholder DOB:** |
| **Secondary Insurance:** | **Secondary Insurance Policy #:** |

Are you referring for: Therapeutic Mentoring In Home Therapy

### Current Diagnoses:

ICD-9 Code:

ICD-10 Code:

### Reason for Referral

 **Current Medication and Doses:**

**Name of Doctor Prescribing Medication:** \_ \_ **Phone**:

**PCP:**

### Psychiatrist:

**Collateral Contact Information**

**Outpatient Therapist:**

Name:

Phone:

### DCF or DMH Contact Person:

Name: Phone:

### DYS/Probation Contact Person:

Name:

Phone:

### School System:

**Address:**

**Contact(s):\_ \_**

**Additional Information:**

**Signature of Referring Provider** \_ **Date of Referral**\_ \_