CBHI / OUTREACH REFERRAL FORM

Please Check for Services:

❑ **Outreach Services**
Home Based Indivdual Therapy

❑ **IHT Services**
Intensive Family Therapy for child with acute concerns

❑ **Therapeutic Mentoring Services** Specify Referral:

❑ External TM Referral (Please include a copy of the last completed CANS & Treatment Plan)

❑ Internal TM Referral Date of Last CANS:_____
Date of Last Treatment Plan:_____

Client:_____ Date of Birth:_____ Age:_____

Gender:_____ Race:_____ Ethnicity:_____ Smoker/Frequency:_____

Address:_____ City/State:_____ Zip:_____

Special Needs: (Linguistic / Cultural**):**_____ School:_____

Diagnosis:_____

Legal Guardian (If Applicable):_____ Phone Number:_____

Where is Client Currently Residing:_____ Phone Number:_____

Referring Person/Agency:_____ ❑Open @ SSMH

Referring Person/Agency Contact Information:_____

Reason for Referral/IHT concerns:_____

_____

_____

Insurance: ❑ BHS ❑ BMC ❑ MBHP ❑ NetHealth Insurance ID#:_____

Client's Primary Care Physician (Name, Address, Phone Number):_____

_____

**** ********** ***Office Use Only*** **********

Fax To:
Dan Vayda, MSW/LICSW – Program Director
617-745-2792 – Office/Fax
dvayda@ssmh.org

Referral Date:_____
First Contact Attempt:_____
❑Voice Mail ❑Letter ❑Spoke With_____
Second Contact Attempt: _____
❑Voice Mail ❑Letter ❑Spoke With_____

Appointments Offered:_____ **First Date Spoke to Contact:**_____

Date Assigned:_____ **SSMH MR#:**_____ **RU:**_____