aspire health alliance

CBHI IHT, Outreach, Therapeutic Mentoring Referral Form

Please check for services being requested

☐ **Outreach Services**
Home/school based individual therapy

☐ **IHT Services**
Intensive family therapy for children with acute concerns

☐ **Therapeutic Mentoring Services**
Please include a copy of last CANS & Treatment Plan

Client: _____ Date of Birth: _____ Age: _____

Gender: _____ Race: _____ Ethnicity: _____

Smoker: ☐ Yes ☐ No Frequency: _____

Address: _____ City: _____ State: _____ Zip: _____

Special needs: (Linguistic/Cultural) _____ School: _____

Diagnosis: _____

Parent/Legal Guardian: _____ Phone: _____

Referring person/agency: _____ Phone: _____

Reason for referral/justification for IHT (Why individual therapy alone is insufficient): _____

_____

_____

_____

Goals of treatment: _____

_____

Insurance: ☐ BHS ☐ BMC ☐ MBHP ☐ Network Health Insurance ID#: _____

Client's primary care physician: Name _____

Address: _____ Phone: _____

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

Referral Date: _____

Fax to:
Boston area: (617) 847-1991
Brockton area: (617) 745-2792
Plymouth area: (508) 747-7039
Quincy area: (617) 847-1937

First contact attempt date: _____
☐ **Voice message** ☐ **Letter** ☐ **Spoke with:** _____

Second contact attempt date: _____
☐ **Voice message** ☐ **Letter** ☐ **Spoke with:** _____
☐ **Voice message** ☐ **Letter** ☐ **Spoke with:** _____

First date spoke to contact: _____ **Appointments offered:** _____

Date assigned: _____ **Aspire Health Alliance MR#:** _____ **RU:** _____