aspire health alliance

CBHI/OUTREACH REFERRAL FORM

Please check desired services

☐ **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: _____ DOB: _____ Age: _____ Gender: _____

Address: _____ City/Town: _____ Zip Code: _____

Phone: _____ Race: _____ Ethnicity: _____ Smoker/Frequency: _____

Special needs (linguistic/cultural): _____

Diagnosis: _____

School: _____ Address: _____

Parent/Legal Guardian: _____ Phone: _____

Referring Person/Agency: _____ Phone: _____

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

_____

_____

_____

Goals of treatment: _____

_____

_____

Insurance: ☐ MassHealth ☐ Commercial Plan Insurance ID#: _____

Client's Primary Care Physician Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

OFFICE USE ONLY

FAX TO:	**Referral Date:** _____
Boston area: (617) 847-1991 **Quincy area:** (617) 847-1937 **Plymouth area:** (508) 747-7039 **Brockton area:** (617) 745-2792	**First Contact Attempt:** _____ ☐ Voice message ☐ Letter ☐ Spoke with _____ **Second Contact Attempt:** _____ ☐ Voice message ☐ Letter ☐ Spoke with _____
First date spoke to contact: _____ **Date assigned:** _____	Appointments offered: _____ AHA MR#: _____ RU#: _____