aspire health alliance

IHT/Therapeutic Mentor Referral Form

Please check desired services	
☐ **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 Provider: _____ Insurance ID#: _____

Secondary Insurance: _____ Insurance ID#: _____

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

Address: _____ City: _____ Zip: _____

OFFICE USE ONLY

FAX TO: (781) 843-2403	**Referral Date:** _____	
Nikki Lemont, LICSW **Sarah Benson, LICSW** **F: (781) 843-2403**	**First Contact Attempt:** _____ ☐ Voice message ☐ Letter ☐ Spoke with _____ **Second Contact Attempt:** _____ ☐ Voice message ☐ Letter ☐ Spoke with _____	
First date spoke to contact: _____	Appointments offered: _____	
Date assigned: _____	AHA MR#: _____	RU#: _____