



IHT/Therapeutic Mentor Referral Form

| Please check desired services | |
|---|---|
| <input type="checkbox"/> IHT Services Intensive family therapy for children with acute concerns | <input type="checkbox"/> 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: _____ <input type="checkbox"/> Voice message <input type="checkbox"/> Letter <input type="checkbox"/> Spoke with _____ | |
| | Second Contact Attempt: _____ <input type="checkbox"/> Voice message <input type="checkbox"/> Letter <input type="checkbox"/> Spoke with _____ | |
| First date spoke to contact: _____ | Appointments offered: _____ | |
| Date assigned: _____ | AHA MR#: _____ | RU#: _____ |