aspire health alliance
State Designated
Community Behavioral Health Center

# IHT/Therapeutic Mentor Referral

**Please check desired services**

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

☐ **Therapeutic Mentoring Services**
Please include a copy of the last CANS, Treatment Plan and a Comprehensive Assessment with the past 12 months.

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**Client:** _____ **DOB:** _____ **Age:** _____ **Gender:** _____

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

**Phone:** _____ **Race:** _____ **Ethnicity:** _____ **Smoker:** ☐ **Yes** ☐ **No**

**Email:** _____

**Special Needs (linguistic/culturally):** _____

**Diagnosis:** _____

**School:** _____ **Address:** _____

**Parent/Legal Guardian:** _____ **Phone:** _____

**Referring Person/Agency:** _____ **Phone:** _____

**Reason for referral/Justification for IHT (why individual therapy alone isn't sufficient):** _____

_____

_____

**Goals of treatment:** _____

_____

_____

**Insurance Provider:** _____ **Insurance ID#:** _____

**Secondary Insurance:** _____ **Insurance ID#:** _____

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

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

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| **FOR OFFICE USE ONLY** | |
|---|---|
| **FAX to: (781) 843-2403** | **Referral Date:**<br>**First Attempt Date:** _____ ☐ **Voice message**<br>☐ **Letter** ☐ **Spoke to:** _____ |
| **Attn:**<br>Nikki Lemont, LICSW<br>Sarah Benson, LICSW | **Second Attempt Date:** _____ ☐ **Voice message**<br>☐ **Letter** ☐ **Spoke to:** _____ |
| **First date spoke to contact:** _____ | **Appointments offered:** _____ |
| **Date assigned:** _____ | **AHA MR#:** _____ **RU#:** _____ |

Revised 4/2023