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 last CANS, Treatment Plan and a Comprehensive Assessment with the past 12 months

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

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

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

Frequency: _____ **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:** _____

FOR OFFICE USE ONLY

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

Revised 2/2024