

Therapeutic Mentoring Referral Form

(Please provide release of information)

Date of Referral: _____

Recipient Name: _____

Date of Birth: _____

Guardian(s) Name: _____

Relationship to Child: _____

Address: _____

Phone Number(s): _____

MMIS: _____

Type of MassHealth: _____

Diagnosis: _____

Medications: _____

Clinical Hub Service Referral Source:

ICC

IHT

Outpatient

Referral Source Contact Information:

Name: _____

Number: _____

Agency: _____

Additional Providers Involved: _____

Identified Goal(s) for Therapeutic Mentor (Please attach a copy of the Tx Plan):

Please identify potential modalities, techniques, strategies and frequency of service

Risk Factors: _____

Recipient Strengths and Protective Factors:

*Please fax this referral form and Release of Information to 508-824-0111. Please call 508-977-8124 to notify that a referral has been sent.

