

**Community Counseling of Bristol County
Therapeutic Mentoring Referral Form**

Date of Referral: _____

Name of Youth: _____ **Date of Birth:** _____ **Age:** __

Guardian(s) Name: _____ **Relationship to Child** _____

Address: _____ **Town:** _____

Phone Number(s): _____

Please identify if DCF maintains legal or chins custody

MMIS #: _____

Please Circle: MBHP BMC beacon NHP beacon Other

Diagnosis Code(s) & Terms: _____

Medications: _____

Clinical Hub Service Referral Source (*required at time of referral in order to obtain authorization and provide services to youth. Incomplete information may delay services)

ICC__ **Name:** _____ **Number:** _____ **Agency:** _____
*Insurance requires CANS, safety plan & updated care plan with descriptive goals specific to mentor

IHT__ **Name:** _____ **Number:** _____ **Agency:** _____
*Insurance requires CANS, safety plan, comprehensive assessment & updated treatment plan with descriptive goals specific to mentor

Outpatient__ **Name:** _____ **Number:** _____ **Agency:** _____
*Insurance requires CANS, comprehensive assessment & updated treatment plan with descriptive goals specific to mentor

Additional Providers Involved: _____

Please identify one or more of these skill building categories when completing the updated treatment plan/care plan with descriptive goals

Socialization Skills Daily Living Skills Problem Solving Skills Conflict Resolution

Anger Management Skills Behavior Management Skills Self- Management Skills

***Please fax this referral form and other required information to 508-824-0111 or if internally making referral put in my mailbox. Please call 508-977-8124 to notify that a referral has been made.**