In-Home Therapy (IHT) Referral Form

Please complete both pages.
Note that incomplete information may delay service delivery.

Date of Referral: _____

Youth Name: _____ **Gender:** _____ **DOB:** _____ **Age** (Birth-21) _____
MassHealth ID#:_____ **Ethnicity:** _____**Phone Numbers:**_____

MassHealth Payer Type: ***(Circle)*** 1) MBHP 2) BMC (Beacon) 3) Tufts 4) Network Health 5) DCF (Family Networks)

Guardian(s) Name: _____ **Relationship to Child**_____
Parent Name (if different):_____
Email address:_____
Address:_____ **Town:**_____ **Zip Code:**_____
Members of Household: _____

DCF Worker: _____ **Phone:** _____***Please identify if DCF custody:*** **CRA or Legal**

Referent Name:_____ **Referring Agency:** _____
Referent Phone:_____ **Referent Address**:_____

If ICC- Have the IHT service units been authorized? Yes____ No_____

Has IHT referral been placed to other agencies? If yes, which agencies?
Has the family received IHT services previously? If yes, which agency? _____ **When?** _____
Reason for termination: _____

Identify family's preference for scheduling: ***(Circle)*** **Weekday** Weekend Either
Details regarding availability:
Have you spoken to the family about this referral? ***(Circle)*** Yes / No **Has the family voluntarily agreed to this referral?** Yes / No

Please list all Psychiatric Hospitalizations, Crisis Visits, or Risk Assessments that have occurred in past (1) one year:

_____
_____
_____

Risk for Re-Hospitalization: 1 2 3 4 5 (1= very low, 3=moderate, 5=very likely)

Check if Primary	ICD-10 Code	**DSM-IV/DSM 5 Narrative Description** (i.e. Major depressive disorder, single episode, moderate)

Other Current Providers (CSA, Psychiatry, Individual Therapist, etc.):

Name	Service	Agency	Phone Number

Reason for Referral/Goals: (symptoms, behavioral/social/emotional functioning of youth/family, focus of treatment):

_____
_____
_____
_____
_____

--Form Continues Onto Next Page--

Reason IHT Level of Care needed *(please check all that apply):*

☐ Outpatient services alone are not sufficient to meet youth and and family's needs for clinical intervention

☐ Need for increased frequency/duration/flexibility of family sessions depending on need in the home and community

☐ Need for 24/7 urgent telephonic response and risk management/safety planning

☐ Youth at risk for out-of-home placement

☐ Need for care coordination with school, other providers, state agencies, natural supports, etc.

☐ High level of risk factors (indicate below)

☐ Need treatment to enhance youth's problem-solving, limit setting, and communication to sustain youth in home

☐ Strengthen caregiver(s) ability to sustain youth in home

At-Risk Factors or Safety Concerns Present *(please check all that apply):*

Youth Risk Factors:

☐ Suicidal Ideations ☐ Suicidal Gestures ☐ Self-Injurious Behavior (cutting, burning, etc.) ☐ Homicidal Ideations

☐ Current Substance Use ☐ History of Substance Abuse ☐ Running Away ☐ Violence/Aggression towards others

☐ Lack of social group ☐ Gang Involvement ☐ Sexualized Aggression/Behavior ☐ Takes dangerous risks ☐ Fire-Setting

☐ School Refusal ☐ Isolates ☐ Medical/Physical, *please explain:* _____

☐ Not medication compliant ☐ Trauma History, *please explain:* _____

☐ Sexual Promiscuity ☐ Other: _____

Caregiver Risk Factors: Please identify which caregiver: _____

☐ Current Substance Use ☐ History of Substance Use ☐ Not medication compliant ☐ Housing Instability

☐ Financial Distress ☐ Current Domestic Violence ☐ History of Domestic Violence

☐ Mental Health Diagnoses - In treatment? _____ ☐ Unable/Unwilling to Provide Adequate Supervision

☐ Medical/Physical Issues, *please explain:* _____

☐ Lack of Natural Supports ☐ Other: _____

Safety Concerns for Home-Based Clinician to Plan For:

☐ Unsafe Neighborhood ☐ Current Domestic Violence ☐ Violent Family Member or Person Involved With Family
Describe_____

☐ Lack of Safe Parking Available ☐ Aggressive Animals ☐ Suspected Illegal Substances in Home ☐ Weapons in Home

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Please fax, email, or place in Intake Supervisor's mailbox and call or email to inform of referral:

IHT and TM Intake Supervisor

Phone: 508-977-8129 Fax: 508-824-0111 Email: IHT.TMReferral@comcounseling.org

* Please note: All referrals will be responded to within 24 hours. If this referral needs to be placed after 6pm Friday or during the weekend, please use alternative intake contact phone number: 508-857-8157.

Thank you for placing this referral with CCBC.

Internal Use Only

Assigned to: Clinician_____ TT&S_____

Date Assigned_____

Phone/Email Sent_____ Initial_____