**In-Home Therapy (IHT) Referral Form**

**Family Therapy**

*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 Number(s):**

**MassHealth Payer Type:** [ ]  MBHP [ ]  BMC (Beacon)[ ]  Tufts Network Health [ ]  DCF (Family Networks)

**MassHealth:** [ ]  Primary[ ]  Secondary

**Commercial Insurance:** [ ]  BCBS [ ]  Optum [ ]  Tufts [ ]  Beacon Health Options **Subscriber name:**        **Relationship to the youth:**       **Subscriber D.O.B.:**        **Plan Effective Date:**       **ID #:**      **Phone Number on back of the card:**        **Copy of the card:** [ ] Yes [ ]  No

 **(Please note that we will not be able to begin services without front/back copies of the card)**

**Guardian(s) Name:**      R**elationship to Child**:

**Parent Name (if different):**

**Email address:**

**Address:**       **Town:**       **Zip Code:**

**Names and Ages of Members of Household:**

**DCF Worker:**       **Phone:** ***\*Please identify if DCF custody:*** [ ]  CRA or [ ]  Legal

**Referent Name:**       **Referring Agency:**

**Referent Phone:**       **Referent Address**:

**Email 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?** Yes[ ] No [ ]  **Has the family voluntarily agreed to this referral?** Yes[ ]  No [ ]

**Is the family currently able to commit to the required 3 hours per week of IHT family therapy?**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** |  **DSM 5** **Code** | **DSM 5 Narrative Description** (i.e. Major depressive disorder, single episode, moderate) |
|  |  | fsdsd |
|  |  |  |
|  |  |  |
|  |  |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Service** | **Agency** | **Phone Number** |
|  |  |  |  |
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**Reason for Referral/Goals: (symptoms, behavioral/social/emotional functioning of youth/family, focus of treatment):**

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

[ ] Currently engaging in weekly individual therapy, [ ] Need for increased collaboration with school, other

 but outpatient services alone are not sufficient to meet youth and providers, state agencies, natural supports, etc

 family’s needs for clinical intervention

[ ]  Need for increased frequency/duration/flexibility of family [ ]  High level of risk factors (indicate below)

 sessions due to clinic based family therapy sessions not being

 sufficient to meet youth and family’s needs

[ ]  Need for 24/7 urgent telephonic response and risk [ ]  Need treatment to enhance youth’s problem-solving,

management/safety planninglimit setting, and communication to sustain youth in home

[ ] Youth at risk for out-of-home placement [ ]  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 [ ]  Not medication compliant [ ]  Sexual Promiscuity

[ ]  Medical/Physical, *please explain:*

[ ]  Trauma History*, please explain:*

[ ]  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

[ ]  Lack of Natural Supports [ ]  Unable/Unwilling to Provide Adequate Supervision

[ ]  Medical/Physical Issues, *please explain:*

[ ]  Mental Health Diagnoses - In treatment?

[ ]  Other:

**Safety Concerns for Home-Based Clinician to Plan For:**

[ ]  Unsafe Neighborhood [ ]  Current Domestic Violence [ ]  Violent Family Member or Person Involved With Family

[ ]  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 IHT mailbox and call or email to inform of referral:

**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 send the referral by email only.

 ***Thank you for placing this referral with CCBC.***

**Internal Use Only**

Assigned to: Clinician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TT&S\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Assigned\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Email Sent\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_