**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?** YesNo  **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_