



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) NHP (Beacon) 4) Network Health 5) DCF (Family Networks)

Guardian(s) Name: _____ Relationship to Child _____

Parent Name (if different): _____

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):

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

- Outpatient services alone are not sufficient to meet youth 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

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 _____