

200 May Street
South Attleboro, MA 02703

In-Home Therapy and Therapeutic Mentoring Program

Referral Form

• Phone (508) 838-4193 • Fax (508) 838-2303

For IHT Referrals PLEASE SEND: [] Referral Form (with all required sections completed)

For TM Referrals PLEASE SEND: [] Referral Form [] CANS [] Safety Plan [] Youth's Tx Plan (w/ TM goals) Comprehensive Assessment
(All 5 documents must be sent for TM referral to be considered complete)

Send referrals via EMAIL: FullerIHTTM@uhsinc.com or FAX: (508) 838-2303

TM referrals are to be made by child's outpatient therapist, IHT or ICC.

This a referral for (check one)

[] In-Home Therapy/FST

[] Therapeutic Mentoring

For IHT/TM, we accept the following MassHealth insurance types: MBHP, BMC, and Tufts Health Plan

For all insurances, services require prior authorization. Please provide the MassHealth Ins. Type & Number and SSN below

Authorization Information

Insurance type _____ Policy/MMIS # _____ SSN _____

Leave this section blank (this section is to be filled out by Fuller Hospital IHT/TM Program)

Authorized dates of service _____ # Units authorized _____

Authorization # _____

Client's name _____ Gender _____ DOB _____ Age _____

Address _____ Zip _____

Guardian's name(s) _____ Relationship to client _____

Phone (home) _____ Alternate phone (cell) _____ Other _____

Does the client or guardian speak English? _____ If not, preferred language _____

Name of Person Referring _____ Agency/Service Provided _____

Phone _____ Fax _____ e-mail _____

Has the family agreed to services? [] Y [] N Are there any outstanding 51As? [] Y [] N

Does the home environment pose a safety risk? [] Y [] N If Yes, Explain:

Current diagnoses if known (please include DSM-V ICD-10 code)

Psychiatric Diagnosis: _____

Medical Diagnosis: _____

Psychosocial Stressors: _____

Reason for Referral:

Precipitants to Referral (Family, friends, school stressors? Recent upsetting events? High risk factors?)

Current Medication and Doses:

Short term treatment recommendations:

Other Provider Information (required if applicable):

Therapist _____ Address/Number _____

Med Prescriber _____ Address/Number _____

PCP/Pediatrician _____ Address/Number _____

School Presently Enrolled _____ Address _____

School Contact(s) _____ Number(s) _____

DCF DMH DYS DDS Name(s)/Role(s) _____

Address(es)/Number(s) _____

Other _____

Other _____

Other _____

Signature of Referring Provider _____ Date _____

Thank you for the referral.