FULLER HOSPITAL
LEADING THE WAY IN BEHAVIORAL HEALTH

200 May Street
South Attleboro, MA 02703

In-Home Therapy and Therapeutic Mentoring Programs

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

Referral Form

This is a referral for (check one): ☐ **In-Home Therapy** ☐ **Therapeutic Mentoring**

TM referrals are to be made by youth's Hub provider (ICC, IHT, or outpatient therapist)

*For **IHT Referrals** PLEASE SEND*: ☐ **Referral Form (with all required sections completed)**

*For **TM Referrals** PLEASE SEND:* ☐**Referral Form** ☐ **CANS** ☐ **Safety Plan** ☐ **Tx Plan (w/ TM goals)** ☐ **Comprehensive Assessment**
(All 5 documents must be sent by the *Hub provider* for TM referral to be processed)

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

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

Insurance Type:	**Policy/MMIS #:**	**SSN:**
Authorization Information: (Please leave this section blank, it is to be filled out by Fuller Hospital IHT/TM Program)		
Dates of service:	**Auth #**:	**# Units Authorized**:

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:

Special accommodations or requests:

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

Psychiatric Diagnosis: _____

Medical Diagnosis: _____

Psychosocial Stressors: ☐ Primary Support Group ☐ Social Environment ☐ Educational ☐ Occupational
☐ Housing ☐ Economic ☐ Legal ☐ Access to Health Care ☐ Other: _____

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: Phone:

Address: Fax:

Med Prescriber: Phone:

Address: Fax:

PCP/Pediatrician: Phone:

Address: Fax:

School Presently Enrolled: School Contact(s):

Address: Phone/Fax:

☐**DCF** ☐ **DMH** ☐ **DYS** ☐ **DDS /** Name(s)/Role(s):

Address(es)/Number(s):

Legal Guardian (if different than custodial guardian):

Other:

Other:

Signature of Referring Provider: **Date**:

Thank you for the referral.