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**.
Some commercial plans are accepted, please call to verify eligibility. For all insurances, services require prior authorization.

| **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.***