ARBOUR-FULLER HOSPITAL

A Division Of Arbour Health System

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 Tool** ☐ **Youth's Individualized Tx Plan (with TM goals identified)**

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)

☐ **FST/In-Home Therapy** ☐ **Therapeutic Mentoring**

For **IHT/TM**, *we accept the following insurances types*: **MBHP, Network Health/Tufts, BMC Healthnet, NHP & Fallon**

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 AFH 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.