Northeast Family Services

In Home Behavioral Services (IHBS) Referral Form

Please complete both pages.

Note that incomplete information may delay service delivery.

Date of Referral: _____

Youth Name: _____ DOB: _____ Known as: _____

MassHealth ID#: _____ Language required for services: _____ Sex: ___ Age (3-21): _____

Indicate MassHealth Payer Type: ***Family Assistance Not Accepted***

1) MBHP 2) Beacon (BMC, Fallon, Wellforce) 3) Tufts Network Health 4) NHP

Guardian's Name: _____ Relationship to youth: _____

Guardian's Phone Number: _____ Address: _____

Town: _____ Zip Code: _____ Parent(s) name if different: _____

Member's of the household: _____

DCF Worker: _____ Phone: _____ *Please identify if DCF custody: CRA or Legal

Referent Name: _____ Referring Agency: _____

Referent Phone: _____ Referent Address: _____

If ICC- Have the IHBS service units been authorized? Yes or No

Has an IHBS referral been placed to another agency at the same time? If yes, which agencies? _____

Has the client received IHBS services previously? If yes, which agency _____

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):

_____

_____

_____

_____

_____

Medications:

	Name	Dose	Frequency	Indication		Name	Dose	Frequency	Indication
1.					2.				

Family's Preference for Scheduling: SU M T W TH F SA Times: _____

Please include the following if you are provider listed below.

ICC Name: _____ Phone: _____ Agency: _____

☐ Care plan and/or units have been submitted and authorized

☐Attach Current CANS

☐Attach comprehensive assessment

☐Attach Updated care plan with IHBS goal(s)

☐Attach Updated safety plan

IHT Name: _____ Phone: _____ Agency: _____

☐ Attach Updated treatment plan with IHBS goal(s)

☐ Attach comprehensive assessment

☐ Attach Current CANS

☐ Attach Updated safety plan

Outpatient Name: _____ Phone: _____ Agency: _____

☐ Attach Updated treatment plan with IHBS goal(s) ☐ Attach Current CANS D Attach comprehensive assessment

Please identify one or more of these skill building categories to be included on the updated treatment plan/care plan with descriptive goals that include IHBS interventions ***(please circle):***

Physically Aggressive Behavior Verbally Aggressive Behavior Non-Compliance School Refusal

Tantrums Behavior Management Skills Self- Management Skills

At-Risk Factors or Safety Concerns Present *(please check all that apply):*

☐ Suicidal Ideations

☐ Suicidal Gestures

☐ Self-Injurious Behaviors

☐ Homicidal Ideations

☐ Current Substance Use

☐ Hx of Substance Abuse

☐ Runs Away

☐ Violence/Aggression towards others

☐ Takes Dangerous Risks

☐ School Refusal

☐ Lack of Social Group

☐ Gang Involvement

☐ Med Compliance Issues

☐ Fire Setting

☐ High Risk Sexual Activity

☐ Isolates

☐ Sexualized Aggression and/or behaviors

☐ Trauma history, please explain: _____

☐ Medical/Physical Issues, please explain: _____

Safety Concerns for Home-Based Team to Plan for *(please circle all that apply):*

Unsafe Neighborhood
Current Domestic Violence

Violent Family Member or Person Involved with Family

Lack of Safe Parking Available

Animals (Please list below for allergies)

Suspected Illegal Substances in Home

Weapons in Home

Please describe: _____

_____

To complete referral:

Fax or mail this form and any attachments to:
Fax: (774) 628-9657

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