CENTRO | 11 Sycamore Street | Worcester, MA 01608 | centroinc.org | 508.798.1900

CHILDREN'S BEHAVIORAL HEALTH INITIATIVE

Therapeutic Mentor Referral

REFERRAL SOURCE		
☐ In Home Therapy ☐ Intensive Care Coordinator ☐ Out Patient Therapy		
Date	**Agency**	**Telephone**
Name	**E-Mail**	

Please attach the following documentation:

☐ Current CANS- ICC/IHT/OP ☐ Treatment Plan- IHT/OP ☐ Safety Plan-IHT/ICC

☐ Care Plan and units authorized- ICC ☐ Comprehensive Assessment-OP/IHT

Member Information (Youth being referred)			
Insurance:		**MMIS #:**	
Complete Name		**DOB**	**Gender**
Guardian	**Relationship**	**Phone Number**	
Address		**Town**	**Zip Code**

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Portuguese** ☐ **Other** _____

Family Availability/Times: _____

Primary Diagnosis : _____

Other Services in the Home (DCF/DDS) _____

Identify one or more of these skill building categories to be included in updated treatment plan/care plan with descriptive goals that include TM interventions

☐ Socialization ☐ Daily Living ☐ Problem-Solving ☐ Conflict-Resolution

☐ Anger Management ☐ Behavioral Management ☐ Self- Management

At-Risk Factors or Safety Concerns

☐ Suicidal Ideations/Gestures ☐ Homicidal Ideations/Gestures ☐ Substance Abuse

☐ Aggressive Behaviors ☐ Run-away Behaviors ☐ Gang-Involvement

☐ School Refusal ☐ Sexual Promiscuity ☐ Isolates

Safety Concerns ☐ NONE

☐ Unsafe Neighborhood ☐ Current Domestic Violence ☐ Violent Family Member

☐ Pets_____ ☐ Suspected Substance Abuse ☐ Weapons in Home

Reason for Referral/HX of client/Other Helpful Information:

Please Note that the following criteria exclude youth for TM services:

- The youth displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more intensive service beyond community-based interventions
- The youth has medical conditions or impairment that would prevent beneficial utilization of services
- TM not needed to achieve identified treatment goal
- Youth's primary need is only for observation or for management during sport/physical activity, school, after-school activities, or recreation, or for parental respite
- The service needs identified in the treatment plan/ care plan are being fully met by similar services
- The youth is placed in a residential treatment setting with no plans for return to a home setting

Visit masspartnership.com for more information

To Complete Referral:
Fax form and attachments: 508-798-1914
Scan and email: cbhireferrals@centroinc.org

CBHI STAFF USE ONLY	
☐ Current CANS ☐ Treatment Plan ☐ Safety Plan ☐ Care Plan and units authorized ☐ Comprehensive Assessment	
Assigned to	**Date**