The EDINBURG CENTER

Children's Services (CBHI) Intake (781) 761-5060 Fax: 781-275-7207
205 Burlington Road • Bedford, MA 01730

Date:

IHT (In Home Therapy) Referral Form

1: Youth Information:			
Youth Name:			
Address:			
City:	State:	Zip:	
Date of Birth: Age:	Ethnicity:	Gender:	

2: Parent/Guardian & Family Information			
Parent/Guardian & Name:		Relationship:	
Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email address:			
Parent/Guardian Name:		Relationship:	
Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email address:			

Foster Family ☐ Yes ☐ No Adoptive Family ☐ Yes ☐ No

Primary Language Spoken at Home: Spoken by youth:

Safety concerns in-family: ☐ Yes ☐ No neighborhood ☐ Yes ☐ No (describe on separate sheet):

Siblings names, ages, gender:

Names of other adults living in the house: Caregiver?

_____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No

Family Availability:			
Days of the Week:		Start time:	End Time:
Monday			
Tuesday			
Wednesday			

Thursday			
Friday			
Saturday			
Sunday			

3: Insurance Information: (Must be MassHealth Standard, Commonhealth or Family Assistance)

MassHealth # (MMIS): MCE # (if applicable):

MassHealth MCE (Behavioral Health) plan (circle one):

MBHP Tufts-Network Neighborhood (NHP) Fallon BMC (Boston Medical)

4: Medical Necessity Criteria: (must answer YES to 1-5)

1. The youth's clinical condition warrants this service in order to enhance, interpersonal communication, problem-solving, limit-setting, conflict resolution and risk management/safety planning ☐ Yes ☐ No
2. To advance therapeutic goals or improve ineffective patterns of interaction**?** ☐ Yes ☐ No
3. Build skills to strengthen the parent/caregiver's ability to sustain the youth in their home setting or to prevent the need for more intensive levels of service such as inpatient hospitalization or other out of home behavioral health treatment services? ☐ Yes ☐ No
4. The youth resides in a family home environment (or foster, adoptive) and has parent/caregiver who voluntarily agrees to participate in In Home Therapy Services?: ☐ Yes ☐ No
5. Outpatient services alone are not or would not likely be sufficient to meet the youth and family's needs for clinical intervention/treatment? ☐ Yes ☐ No

Please attach any of the following possible MassHealth documentation:

☐ **Release of Information (if not parent)** Copy attached: ☐ Yes ☐ No

☐ **Care Plan (if ICC)** Copy attached: ☐ Yes ☐ No

☐ **CANS** Copy attached: ☐ Yes ☐ No

☐ **Comprehensive Assessment** Copy attached: ☐ Yes ☐ No

☐ **Risk Management/Safety Plan** Copy attached: ☐ Yes ☐ No

5: Medical Information:

Diagnoses (DSM 5 diagnosis & ICD 10 codes:

Who made the diagnosis (name/title)

Practice/Agency:

Address: Phone:

City: State: Zip:

Primary Physician: Phone:

Practice Name:

Address:

City: State: Zip:

Please attach latest physical and immunization record Copy attached: ☐ Yes ☐ No:

Name &describe any youth medical concerns:
Does youth have allergies (list type):
Does youth have history of seizures:
Describe any youth physical or other intellectual disabilities:
Does youth take medication (list name, dosage and times):

6: Others involved with youth:	
Intensive Care Coordinator (ICC): Family Partner: Agency:	Phone: Phone: Phone:
Prescriber: Practice:	Phone: Phone:
Outpatient Therapist: Facility:	Phone: Phone:
IHBS Clinician: Monitor: Agency:	Phone: Phone:
Therapeutic Mentor: Agency:	Phone: Phone:
State Agency (DCF, DMH, DYS): Worker:	Phone: Phone:
Natural Support:	Phone:
Other:	Phone

7: School Information:		
School/Daycare/ EI name:		Grade:
Address:		
City:	State:	Zip:
School contact name:	Phone:	
Type of classroom (circle one): Reg Ed Self-contained Inclusion Home based		
Date of last IEP:	Copy attached: ☐ Yes ☐ No	
School Behavior Support Plan: ☐ Yes ☐ No	Copy attached: ☐ Yes ☐ No	

8: Description of presenting issues:

Circle concerns then describe:

Verbal/physical aggression Depression Self-injury Non-compliance Conflict Sibling relationships

Inflexibility Limit-setting Substance use Emotional regulation Eating/mealtime concerns

Sleeping/bedtime issues Tantrumming Anxiety Parent/child relationships Other _____ Please describe what the concerns look like:
How often do the concerns occur? (specify frequency per day/week, length and level of intensity)
Describe how the challenges are currently handled:
Describe how effective the procedures are in: a) assisting skill building b) decreasing/increasing the frequency or intensity of the challenges:
Describe any challenges that occur at school:
Describe any challenges that occur in the community:
Has the youth been hospitalized, CBAT, placed residentially or used emergency respite in the last two years? Briefly explain:

9: Referral source (If other than parent/guardian)		
Referral Name:		Relationship:
Agency/Practice/Facility:		
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email address:		