The EDINBURG CENTER

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

Date:

TM (Therapeutic Mentoring) 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

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

Thursday			
Friday			
Saturday			
Sunday			

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

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. 2 & 3)

1. Does the youth require education, support, coaching & guidance in age-appropriate behaviors, interpersonal communication, problem-solving, and conflict resolution and relating appropriately to others to address daily living, social, and communication needs and to support the youth in a home, foster home or community setting?
   OR Is the youth at risk for out-of-home placement as a result of the youth's mental health condition?
   OR Does the youth require support to transition back to the home setting from a congregate care setting? ☐ Yes ☐ No
2. Outpatient services alone are not sufficient to meet the youth's needs for coaching, support and education? ☐ Yes ☐ No
3. Youth is engaged in OP, IHT or ICC and provider can determine the attainment of the identified goals that pertain to the development of communication skills, social skills and peer relationships?: ☐ Yes ☐ No

Please attach the required MassHealth documentation:

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

☐ **Treatment Plan <u>with a goal for TM</u>** 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:
In Home Therapist (IHT): TT&S: Agency:	Phone: Phone: Phone:
Outpatient Therapist: Agency:	Phone: Phone:
IHBS Clinician: Monitor: Agency:	Phone: Phone:
State Agency (DCF, DMH, DYS): Worker:	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 goal for TM
Circle concerns then describe: Verbal/physical aggression Depression Self-injury Non-compliance Conflict Peer relationships

Inflexibility Poor problem-solving Emotional regulation Lack of engagement in the community Pre-vocational skills Anxiety Isolation Other _____ Please describe what the concerns look like as goals for TM:
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 challenges that occur at school?
Describe 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		
Referral Name:		Relationship:
Agency/Practice/Facility:		
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email address:		