Riverside Community Care

Leading the Way in Behavioral Healthcare & Human Services

LIFESKILLS REFERRAL

**Please fill out and return to: Kerry Roberts**

DMH-
361 Plantation St.
Worcester, MA 01605
T: 774.420.3104
F: 774-420-3166.

Kerry.roberts@mass.gov

1. Client Name: 2. Date of Referral:

3. Date of Birth: 4. Identified Gender:

5. Current Address:

6. Telephone Number:

7. Parent/Guardian Address:

Parent/Guardian: Parent/Guardian:

Tel.# Tel.#

8. Guardianship / Custody Status:

Name:

Address:

9. Emergency Information:

10. Presenting Problem: (Be specific about behaviors)

11. Goals (Life Skills)

12. Response to redirection and limit setting:

Other:

13. Entitlements: ( Please check appropriate Entitlement)

| | | | |
|---|---|---|---|
| GRF (General Relief) | ( ) | AFDC | ( ) |
| SSI (Social Security Income) | ( ) | Other(Please Define) | ( ) |

14. Education:

| | |
|---|---|
| Grade: | School: |
| Town: | Date of CORE Evaluation: |
| Date of IEP: | |

15. Psychiatric Hospitalizations: Total Number:

| Hospital (Most Recent) | Date | Reason for Hospitalization |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

16. Out – Home – Placements:

| Placement | Date |
|---|---|
| | |
| | |
| | |
| | |

17. DSM Diagnosis:

Date: Where From:

| Code | Diagnosis |
|---|---|
| | |
| | |
| | |
| | |
| | |

18. Symptomatology:

History of any of the following:
(C = Current, H = History, B = Both)

| | |
|---|---|
| Suicidality ( ) | Assaultive ( ) |
| Fire Setting ( ) | Escape Risk ( ) |
| Sexualized Behaviors ( ) | Sexual Abuse ( ) |
| Self-Harm ( ) | Psychotic Symptoms ( ) |
| Aggressive ( ) | Oppositional/Defiant ( ) |

Other _____

If reported current and/or history of any of the above symptoms, please explain:

_____
_____
_____
_____
_____
_____

19. DHM application submitted ( ) yes ( ) no

20. Drug / Alcohol Abuse (Be specific around type, frequency, and duration):

_____
_____
_____

21. Prescribed Medications / Known Allergies or Medical Problems:

a. Medications b. Allergies / Medical Problems

_____
_____
_____
_____

22. Multigenerational Family History:
(Briefly mention psychiatric, drug/alcohol, or abuse history):

_____
_____
_____
_____

23. Criminal Justice History:

_____
_____
_____

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24. Contacts: (Include Telephone Number):

A. DMH (Dept. of Mental Health) _____
B. DYS (Dept. of Youth Services) _____
C. DCF (Dept. of Children and Families) _____
_____
D. SPED Liaison (School) _____
E. Therapist _____
F. Psychiatrist _____
G. Other (Please Explain)

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25. Insurance: Policy #

26. Referral Source:

Name: _____Relationship: _____

Telephone Number: _____

Additional information (to speed referral)

☐ DMH Application if not already approved or submitted

☐ Any Clinical Documentation to support Diagnosis (testing, discharge summaries…)