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www.FSMV.org

Therapeutic Mentoring Referral

TODAY'S DATE: **FSMV USE: Date received:**

Name of referred youth:_____ DOB:_____ ____Male ____Female

Name of caretaker:_____ If a minor, who has legal and physical custody?_____

Address:_____

Primary Language of referred youth:_____ Primary language of caretaker:_____

Preferred phone number:_____ Back up/alternative phone number:_____

Mentor preference: ☐ Male ☐ Female ☐ Either Best times to call/Scheduling needs:

Name of person referring client: _____ Role with family:_____

Agency name (if applicable):_____

Type of provider/agency (*please check only one*):

☐ CSA ☐ Outpatient Mental Health ☐ 24-hr. care (e.g. hospital, CBAT, TCH, STARR)

☐ In-Home Therapy (IHT) ☐ ESP/Mobile Crisis Intervention ☐ Other: _____

Phone: Fax: Email:

Client has: MBHP - NETWORK – NEIGHBORHOOD HEALTH PLAN – Beacon (circle one)
ID# (For Network Health, list N number; for NHP, list NHP number

_____

Current ICD-10/DSM-5 Diagnosis (number and brief description):_____

Who generated diagnosis and when?

Have you explained TM Services to the family? *Yes* ❑ *No* ❑ Has the family agreed to the service? *Yes* ❑ *No* ❑

Reasons for referral and identified goals (check all that apply):

☐ Requires education, support, coaching and guidance in age-appropriate behaviors, interpersonal communication, problem solving and conflict resolution, and relating appropriately to others.

☐ Requires support in transitioning back to the home, foster home or community from a congregate care setting.

☐ Other:_____

A Therapeutic Mentoring goal related to building specific skills in a community environment must be included in the current treatment plan.

Please fax current Comprehensive Clinical Assessment, Treatment Plan/Care Plan/Individualized Action Plan including a clear TM goal, and current CANS indicating that the youth's clinical condition warrants this service.

Name/phone number of therapist (if not noted above):_____

Does the home pose any safety risk to the team including domestic violence, outstanding 51A's, active substance abuse? *Yes* ❑ *No* ❑
If yes, please explain:

FAX to Krystal Dunn at 978-327-6601 or E-MAIL: KDunn@fsmv.org