Riverside Community Care

THE HELP YOU NEED CLOSE TO HOME

Community Service Program (CSP) Referral Form

In order to evaluate your request for referral to CSP and/or Outpatient services we need the referral form completed in full and **emailed to CSPReferral@Riversidecc.org** or **Faxed to 781-355-4277**. Please include a signed release and current medication list if available. Once the information is received program management will review it within 48 business hours.

REFERRAL SOURCE INFORMATION	
Date of Referral:	Referral for: ☐ Outpatient Services & CSP ☐ CSP ONLY
Name of person making referral:	
Name of Organization:	Contact Email:
Telephone Number:	FAX Number:
Client is aware this referral is being made: ☐Yes ☐No Commments:	Client is agreeing to/wanting services: ☐Yes ☐No Comments:

CLIENT INFORMATION				
Client Name:		DOB:	Gender:	
Home Address:	City:		State:	ZIP:
Home Telephone:	Cell Telephone:	Best time to contact:		
Client's Insurance: ☐MBHP ☐Celticare ☐Commonwealth Care Alliance ☐Beacon/Fallon (Medicaid only) ☐Beacon/NHP (Medicaid only) ☐Beacon/BMC Healthnet (Medicaid) ☐Tufts Health Plan (NHP)			Insurance Number/RID #:	
Client's Cultural or Ethnic Background:		Preferred Language:		
Subscriber Name:		Relationship to Patient:		
Guardian: ☐N/A ☐Name:		Guardian Telephone:		
Developmental/cognitive/communication concerns/issues/needs:				

COLLATERAL & PROVIDER INFORMATION				
Agency/Provider Name	Contact Person	Phone Number	FAX Number	Address/Service Location
Primary Care Clinician				
Outpatient Therapist				
Psychiatrist				
Specialist:				
DMH				
DCF				
Other:				

REFERRAL INFORMATION
Reason for referral to CSP and history of presenting condition: **(REQUIRED)**
Suggested goals for CSP: **(REQUIRED)**
Risk factors/suicidality/violence at time of referral: **(REQUIRED)**
Relevant medical conditions and/or concerns (if any):
Legal/court history and current involvement:
Substances used/misused in the past year (if known):

Diagnosis: include diagnosis name and ICD-9 or ICD-10 codes for any primary or secondary diagnosis		
Primary Diagnosis: **(REQUIRED)**	ICD-9 code:	ICD-10 code:
Additional Diagnosis:	ICD-9 code:	ICD-10 code:
Additional Diagnosis:	ICD-9 code:	ICD-10 code:
Additional Diagnosis:	ICD-9 code:	ICD-10 code:

CLINICAL CRITERIA FOR REFERRAL (please select as many as appropriate)

Acute Psychiatric Care Services:

☐52 days or more of acute Behavioral Health level of care (i.e., 24-hour level of care such as inpatient, DDART, ART, detox, etc.) during the past 12 month period
☐Readmission to an acute Behavioral Health level of care within a: ☐6 month period ☐12 month period
☐Initial admission to an acute Behavioral Health level of care where cultural or linguistic needs are present
☐Initial admission to an acute Behavioral Health level of care for a Member with a newly diagnosed Major Mental illness
COMMENTS: _____

Treatment Engagement:

☐Non-attendance of psychotherapy appointments
☐Non-attendance of medication appointments
☐Poor attendance or inappropriate use of health services (e.g., >2 ER visits in 6 months, no primary care visit within a 1 year period)
☐Multiple use of behavioral and medical emergency services with poor follow through, which is likely to result in hospitalization
☐Unresponsiveness to behavioral health or medical services placing the Member at risk for hospitalization:
☐Unresponsive to services for 3 months ☐Unresponsive to services for 6 months
☐3 or more unsuccessful outreach attempts by medical and/or behavioral health providers
COMMENTS: _____

Clinical Risk:

☐Catastrophic event(s) which place the Member at risk for behavioral health hospitalization
☐Homeless individuals with a history of mental illness and/or substance abuse
☐Active use of alcohol and/or drugs during pregnancy
☐Co-morbidity of behavioral health diagnosis and complex medical illness and/or physical disability
COMMENTS: _____

Other Conditions:

☐Multiple family members utilizing behavioral health and/or state agency services
☐"Aging-out" of DCF, DYS, DMH or special education services by a Member who also has a behavioral health diagnosis
☐Presence of ethnic, linguistic, and culturally sensitive issues
☐Member utilizing acute Behavioral Health levels of care and is responsible for child(ren) under age of five
COMMENTS: _____

For Child and Adolescent referrals, please indicate if any of the following apply:

☐Child and family failing to stabilize during extended CBHI services
☐Newly diagnosed with a major mental illness which places the child at risk for acute Behavioral Health levels of care
☐Parent with a history of substance abuse and/or mental illness, which puts child at risk
☐Extensive history of trauma
☐Failed out of home placement(s) during the past 6 months
☐Transitioning from a long term care placement or state facility to the community
COMMENTS: _____

For Inpatient Facilities Only	
Discharge Date:	
Discharge Plan:	

Questions may be directed to Nora Kenny-Houser, LICSW at 781-247-0090
With this form PLEASE INCLUDE: a Signed ROI, Current Medication List, Discharge and Admission Summary if available.

*(Riverside Staff ONLY) Referral Received by :*_____ *Date Received:*_____