Riverside Community Care

THE HELP YOU NEED CLOSE TO HOME

LIFESKILLS REFERRAL

Please fill out and return to: Kerry Roberts
DMH-Southwest Suburban
5 Randolph Street, Canton MA 02021
Tel # 781-401-9716 Fax: 781-401-9721

1. Client Name: 2. Date of Referral:

3. Date of Birth: 4. S.S. #:

5. Current Address:

6. Telephone Number:

7. Parent's Address:

Mother: Father:

Tel.# (H) (W) Tel.# (H) (W)

8. Guardianship / Custody Status:

Name:

Address:

9. Emergency Information:

10. Presenting Problem: (Be specific re: behaviors)

11. Goals (Life Skills)

Other

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12. Entitlements: (Please check appropriate Entitlement)

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

13. Education:

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

14. Psychiatric Hospitalizations: Total Number:

Hospital (Most Recent)	Date	Reason for Hospitalization

15. Out – Home – Placements:

Placement	Date

16. DSM Diagnosis:

Date: Where From:

AXIS I
AXIS II
AXIS III
AXIS IV
AXIS V

17. Symptomatology:

History of any of the following:
(c = Currently, H = History, B = Both)

Suicidality ( )	Assaultive ( )
Fire Setting ( )	Escape Risk ( )
Sexual Deviance ( )	Sexual Abuse ( )

Other (Please Explain)

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

19. Prescribed Medications / Known Allergies or Medical Problems:

a. Medications b. Allergies / Medical Problems

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

21. Criminal Justice History:

22. Contacts: (Include Telephone Number):

A. DYS (Dept. of Youth Services)
B. DSS (Dept. of Social Services)
C. SPED Liaison
D. Therapist
E. Psychiatrist
F. Other (Please Explain)

23. Insurance: Policy #

24. Referral Source:

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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…)