Riverside Community Care

THE HELP YOU NEED CLOSE TO HOME

LIFESKILLS REFERRAL

Please fill out and return to: Kim Irving

DMH-
85 East Newton Street
Boston, MA 02118
T: 617.626.8976
F: 617-626-8794

kimberly.a.irving@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 1: Parent :

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

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 – Of – Home Placements:

Placement	Date

16. DSM Diagnosis:

Date: Where From:

Code	Diagnosis

17. Symptomatology:

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

Suicidality ( )	Assaultive ( )
Fire Setting ( )	Escape Risk ( )
Sexualized Behaviors ( )	Sexual Abuse ( )
Self-Harm ( )	Psychotic Symptoms ( )

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Other (Please Explain) _____

18. DHM application submitted ( ) yes ( ) no

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

_____

_____

_____

20. Prescribed Medications / Known Allergies or Medical Problems:

a. Medications b. Allergies / Medical Problems

_____

_____

_____

_____

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

_____

_____

_____

_____

22. Criminal Justice History:

_____

_____

_____

23. 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)

_____

24. Insurance: Policy #

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25. 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…)