Riverside Community Care

Leading the Way in Behavioral Healthcare & Human Services

Life Skills Center Referral

Please fill out and return to: Samantha Poutas

Samantha.Poutas@mass.gov
DMH
361 Plantation St.
Worcester, MA 01605
T: 774.420.3138
F: 774-420-3166

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)

_____

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…)