

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)

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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

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18. Symptomatology:

History of any of the following:

(C = Current, H = History, B = Both)

Suicidality ()

Fire Setting ()

Sexualized Behaviors ()

Self-Harm ()

Aggressive ()

Assaultive ()

Escape Risk ()

Sexual Abuse ()

Psychotic Symptoms ()

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...)