

# Riverside Community Care

Leading the Way in Behavioral Healthcare & Human Services

## LIFESKILLS REFERRAL

**Please fill out and return to: Stephanie Seretta, LCSW**

DMH

85 East Newton Street

Boston, MA 02118

T: 781-804-9394

[stephanie.seretta2@mass.gov](mailto:stephanie.seretta2@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)

Tel.# (H)

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: 1 Total Number: 1

Hospital (Most Recent)	Date	Reason for Hospitalization
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15. Out-Of-Home Placements:

Placement	Date
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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 ( )

Other (Please Explain) \_\_\_\_\_

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18. DHM application submitted ( ) yes ( ) no

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

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20. Prescribed Medications / Known Allergies or Medical Problems:

a. Medications

b. Allergies / Medical Problems

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21. Multigenerational Family History:

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22. Criminal Justice History:

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23. Contacts: (Include Telephone Number):

A. DMH (Dept. of Mental Health) \_\_\_\_\_

B. DYS (Dept. of Youth Services)

C. DCF (Dept. of Children and Families)

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D. SPED Liaison (School)

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E. Therapist

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F. Psychiatrist

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G. Other (Please Explain)

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24. Insurance:

Policy #:

25. 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...)