Riverside Community Care

Leading the Way in Behavioral Healthcare & Human Services

LIFE SKILLS: LARRY CENTER REFERRAL

Please fill out and return to: Kara McTague, LICSW

Kara.E.McTague@mass.gov
DMH
85 East Newton Street
Boston, MA 02118
T: 617-680-3115

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: 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 ( )

Other (Please Explain) _____

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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:

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…)