Date of Referral: _____ Assigned to: _____ Date: _____

Soth Shore Center for Wellness LTD

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Therapeutic Mentoring (TM) Referral Form

Youth Name: _____ Gender: M F **DOB:** _____ Age: _____

SS#: _____ - _____ - _____ **MMIS #:** _____ **Phone #:** _____

Payer Type: (MBHP) (BMC) (NHP) (Network Health) (DCF-Family networks) **Policy #:** _____

Guardian Name: _____ **Relation to Youth:** _____ **Parent Name:** _____

Address: _____ **Town:** _____ **Zip:** _____
Members of Household: _____

DCF Worker: _____ Phone: _____ Agency: _____

Referral Name: _____ **Referral Agency:** _____

Referral Phone: _____ *If ICC- Have the TM service units been authorized? Y N*

*If clinical provider: please attach CANS, Comprehensive Assessment & Safety Plan (if applicable)

*ICC: attach CANS, Safety Plan & Care Plan

Have you spoken to the family about this referral? Y N Has the family voluntarily agreed to this referral? Y N

Prior/Current Tx or services:

_____

_____

Axis 1 Diagnosis: _____

Significant Impairment in Functioning (Please Circle)

Home School Community

Other: _____

Other Providers (CSA, Psychiatry, Ind. Therapist, Etc.)

_____

_____

_____

Reason for Referral:

_____

_____

_____

Form continues on back

Clinical Hub Referral Source: TM is a *Hub dependent* service, which means the hub is responsible for including TM services on care/treatment plan, updating document quarterly, and maintaining a minimum of weekly phone contact with the assigned TM.

__ICC Name: _____ Phone: _____ Agency: _____

*insurance requires CANS, safety plan and updated care plan with descriptive goals specific to mentor at time of referral.

If referred by the ICC, have the TM service units been authorized? Y N

__IHT Name: _____ Phone: _____ Agency: _____

*insurance requires CANS, safety plan, comprehensive assessment and updated treatment plan with descriptive goals specific to mentor at time of referral.

__Outpatient Name: _____ Phone: _____ Agency: _____

*insurance requires CANS, comprehensive assessment and updated treatment plan with descriptive goals specific to mentor at time of referral.

Please identify one or more of these skill building categories to be included on the updated treatment plan/ care plan:

Socialization Skills Daily Living Skills Problem Solving Skills Conflict Resolution Skills

Anger Management Skills Behavior Management Skills Self-Management Skills

Youth Risk Factors (check all that apply)

- € Suicidal Ideation
- € Suicidal gestures
- € Self- injurious behavior
- € Homicidal ideations
- € *Current substance use
- € *History of substance use
- € Running away
- € Violence/aggression towards others
- € Lack of social group
- € Gang involvement
- € Sexualized aggression/behavior
- € Takes dangerous risks
- € Fire-setting
- € School refusal
- € Isolation behavior
- € Trauma history
- € Medical/physical issues
- € Sexual promiscuity
- € Not medication compliant

*If history of or current substance abuse, has youth ever been admitted to CASTLE? Y N

*** Please note that the following criteria excludes youth for the service:**

1. The youth displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more intensive service beyond community- based interventions.
2. The youth has medical conditions or impairments that would prevent beneficial utilization of services.
3. TM not needed to achieve identified treatment goal.
4. The youth's primary need is only for observation or for management during sport/ physical activity, school, after- school activities, recreation, or parental respite.
5. The service needs identified in the treatment plan/ care plan are being fully met by similar services.
6. The youth is placed in a residential treatment setting with no plans to return to the home setting.

To complete the referral please complete the following steps:

- € (If ICC is Hub) Care plan and/or units have been approved
- € Updated CANS completed & attached
- € Updated treatment/care plan w/ TM goal(s) completed & attached
- € (If IHT or OP is Hub) updated comprehensive assessment completed & attached
- € (If IHT or ICC is Hub) updated safety plan completed & attached