(for MYR nurse use only) Date/Time of Admission Scheduled: _____

Please fax back to (508) 860 1245

MYR SCREENING / REFERRAL FORM

Date: _____ **Time of Initial Call/Fax**: _____

DEMOGRAPHICS:

Client Name: _____

Youth's Current Living Situation: _____

Client Address: _____**Town:**_____ **ZIP:**_____

Client Phone(s): _____

M___ F____ DOB _____ **Age ____ SS#** _____

Preferred language_____ **Will you need interpreter services? Y N**

City of Birth: _____

Race:_____ **Ethnicity:**_____

GENERAL REFERRAL FORM:

HOW DID YOU HEAR ABOUT OUR PROGRAM? _____

Who is referring client to MYR? Name: _____

Referral source relationship to client: _____

Contact Number: _____

Was referrer informed that MYR does not take Section 12s? _____ Yes _____No

Is there a Section 35 in place? _____ Yes _____ No

Guardian Name/Relationship: _____

Guardian Phone(s): Home: _____ Cell: _____

Guardian Name/Relationship: _____

Guardian Phone(s): Home: _____ Cell: _____

Mass Health Insurance: Yes _____ No _____

Mass Health Card#: _____

Which plan? **MBHP**:____ **Fallon**:____ **BMC/Healthnet**: ____ **Network**:_____ **Neighborhood**:____

Run REV

Commercial Insurance:_____

ID#:_____ **Subscriber**:_____

Subscriber Address:_____

Ins. Through Employer? ___Yes ___No

Employer Name:_____

Employer Address: _____

Please remember to bring card

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Reason for referral to MYR currently;
LIST PRECIPITATING EVENT LEADING TO REFERRAL

_____
_____
_____
_____
_____

Describe present drug/alcohol use (last 30 days):

Drug	Amount	Frequency	Method	Last Use

Describe any current psychiatric symptoms or mental health diagnoses: _____

_____
_____
_____
_____

Describe any past treatment for substance abuse or mental health:

Placement	Length of Stay	Reason	Complete/incomplete?

_____

Is the client currently suicidal? _____Yes _____No
Means, method, intent:_____
Is the client currently homicidal? _____ Yes _____ No
Means, method, intent:_____
History of suicide/homicide attempts? _____Yes _____No
Date of last attempt:_____ Method:_____

Risk Factors: (check all that apply):
Self-abusive behaviors: ___ cutting self ___scratching self ___burning self ___none
Eating problems: ___ restricting ___overeating ___bingeing/purging ___none
Aggression/violence ___ toward family ___toward peers ___
___ toward others:_____ ___none
Destructive behavior ___ toward property ___stealing ___fire setting ___none
Running ___ from home ___from programs ___other ___none
Any pending Legal charges? yes _____ no _____ If yes: _____

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OTHER SERVICE PROVIDERS: ****THIS INFO IS USED FOR ROIs****

Record all phone numbers, address or facility name, DCF office or court district

Please provide full name, address and best phone number:

OP Clinician: _____

Address: _____Phone:_____

Probation Officer: _____

Address: _____Phone:_____

DCF: _____

Address: _____Phone:_____

DMH Worker:_____

Address: _____Phone:_____

School Contact: _____

Address: _____Phone:_____

Primary Care Doctor:_____

Address: _____Phone:_____

Therapist: _____

Address: _____Phone:_____

Psychiatrist: _____

Address: _____Phone:_____

Other:_____

Address: _____Phone:_____

Medical Issues:

_____

_____

Allergies:_____

Current Medications:_____

_____

_____

_____

Antipsychotic medications? _____ Yes _____ No

If in DCF custody, was Rogers obtained? ___Yes ___ No

Copy of Rogers provided? _____Yes _____No

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Who will be transporting client? _____

(A legal guardian must sign a minor into the MYR Program)

Who will sign legal paperwork? _____

Prior to admittance to the MYR Program, the following may be requested to be provided to MYR:

- ☐ Emergency mental health screening/evaluation if deemed necessary or hospital discharge summary, if inpatient.

Prior to admittance to the MYR Program, the following must be provided to MYR:

- ☐ Any medications prescribed to the client in the original bottle (except for MAT).
- ☐ Proof of guardianship (in instances of divorce or DCF involvement)
- ☐ Any documentation of information regarding any medical conditions
- ☐ Additional paperwork or labs that would be beneficial for admission if any medical issues
- ☐ **COPY OF INSURANCE CARDS**

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Date	Progress Notes/Referral Updates