Please fax back to (508) 860 1245 **Date/Time of Admission**_____

MYR SCREENING / REFERRAL FORM

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

DEMOGRAPHICS:

Client Name: _____

Youth's Current Living Situation: _____

Client Address: _____**Town:**_____

ZIP CODE:_____

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

M___ **F**___ **DOB** _____ **Age** ____ **SS#** _____

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

City of Birth: _____

Race:_____ **Ethnicity:**_____

GENERAL REFERRAL FORM:

Who is referring client to MYR? _____

Caller name/relationship to client: _____

Contact Number: _(H)_____**(C)**_____

Was referrer informed that MYR does not take Section 12s, even if they say "Transport Only"? – and informed client cannot arrive via ambulance? ____ 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

Reason for referral to MYR at this time; 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

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

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

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

Who will be transporting client? _____

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

Who will sign legal paperwork? _____

Scheduled day and time of arrival:_____

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

- Emergency mental health screening/evaluation if deemed necessary or hospital discharge summary, if inpatient.
- Any medications prescribed to the client in the original bottle.
- Proof of guardianship (in instances of divorce or DCF involvement)
- Additional paperwork or labs that would be beneficial for admissions
- **COPY OF INSURANCE CARDS**

Date	Progress Notes/Referral Updates