

Please fax back to (508) 860-1245

MYR SCREENING / REFERRAL FORM

Date: Time of Initial Call/Fax:

How did you hear about our program?

DEMOGRAPHICS:

Client Name:

Youth's Current Living Situation:

Client Street Address: Apt #:

Town: State: Zip Code:

Client Phone(s):

Male Female Date of Birth: Age: SS#:

Preferred language: Will you need interpreter services? Yes No

City/State of birth:

Race: Ethnicity:

GENERAL REFERRAL FORM:

Who is referring client to MYR?

Caller name/relationship (role) to client:

Contact number: Cell Home Work

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: Beacon: Tufts: Other:

****MYR Nurse Run REV****

Commercial Insurance: ID #:

Subscriber name: Subscriber DOB:

Subscriber address:

Ins. through employer? Yes No Employer Name:

Employer address:

****Guardian: Please remember to bring insurance card to admission or attach a copy to referral****

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	Inpatient/Outpatient	Dates attended	Complete/Incomplete
	In <input type="checkbox"/> Out <input type="checkbox"/>		Complete <input type="checkbox"/> Incomplete <input type="checkbox"/>
Reason:	In <input type="checkbox"/> Out <input type="checkbox"/>		Complete <input type="checkbox"/> Incomplete <input type="checkbox"/>
Reason:	In <input type="checkbox"/> Out <input type="checkbox"/>		Complete <input type="checkbox"/> Incomplete <input type="checkbox"/>
Reason:	In <input type="checkbox"/> Out <input type="checkbox"/>		Complete <input type="checkbox"/> Incomplete <input type="checkbox"/>

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
 other: _____

Eating problems: restricting overeating bingeing/purging none

Aggression/violence: towards family towards peers towards others: _____

Destructive Behavior: toward property stealing fire setting none

Running: from home from programs none other: _____

Legal charges: Yes No **Probation:** Yes No **GPS Monitoring:** Yes No

Details: _____

SERVICE PROVIDERS: **THIS INFO IS USED FOR RELEASES OF INFORMATION**

Please include all phone numbers, address, facility name, etc.

Clinician: [Redacted] **Practice:** [Redacted]

Address: [Redacted] **Phone:** [Redacted]

Probation Officer: [Redacted] **Court District:** [Redacted]

Address: [Redacted] **Phone:** [Redacted]

DCF Social Worker: [Redacted] **DCF Office:** [Redacted]

Address: [Redacted] **Phone:** [Redacted]

DYS: [Redacted]

Address: [Redacted] **Phone:** [Redacted]

DMH: [Redacted]

Address: [Redacted] **Phone:** [Redacted]

School Name: [Redacted] **District:** [Redacted]

School Contact: [Redacted]

Address: [Redacted] **Phone:** [Redacted]

Primary Care Doctor: [Redacted] **Practice:** [Redacted]

Address: [Redacted] **Phone:** [Redacted]

Therapist: [Redacted] **Practice:** [Redacted]

Address: [Redacted] **Phone:** [Redacted]

Psychiatrist: [Redacted] **Practice:** [Redacted]

Address: [Redacted] **Phone:** [Redacted]

Other: [Redacted]

Address: [Redacted] **Phone:** [Redacted]

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? _____

Prior to admittance to the MYR Program, the following may be requested 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 (with the exception of MAT)
- Proof of guardianship (in instances of divorce or DCF involvement)
- Additional paperwork or labs that would be beneficial for admission
- Any documentation or information regarding any medical condition
- Copy of insurance card**
- Copy of Negative COVID-19 test results if performed in the last 72 hours**



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Program Director
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