UMassMemorial Community Healthlink

Date/Time of Scheduled Admission:

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****

Updated 9/19/2020

Date/Time of Scheduled Admission:

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 ☐ Out ☐		Complete ☐ Incomplete ☐
Reason:			
	In ☐ Out ☐		Complete ☐ Incomplete
Reason:			
	In ☐ Out ☐		Complete ☐ Incomplete ☐
Reason:			

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:

Date/Time of Scheduled Admission:

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

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

Clinician: **Practice:**

Address: **Phone:**

Probation Officer: **Court District:**

Address: **Phone:**

DCF Social Worker: **DCF Office:**

Address: **Phone:**

DYS:

Address: **Phone:**

DMH:

Address: **Phone:**

School Name: **District:**

School Contact:

Address: **Phone:**

Primary Care Doctor: **Practice:**

Address: **Phone:**

Therapist: **Practice:**

Address: **Phone:**

Psychiatrist: **Practice:**

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 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**

UMassMemorial
Community Healthlink

Motivating Youth Recovery
26 Queen Street, 5th floor
Worcester, MA 01610
Main Number: 508-860-1244

Program Director
Stephanie Manzi, LMHC
Direct line: 508-860-1171