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 01/25/2021

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 Behavior	**Yes**	**No**
Cutting self	◯	◯
Scratching self	◯	◯
Burning self	◯	◯
Other:		

Eating problems	**Yes**	**No**
Restricting	◯	◯
Overeating	◯	◯
Bingeing/purging	◯	◯

Aggression/violence	**Yes**	**No**
Towards family	◯	◯
Towards peers	◯	◯
Towards others:	◯	◯
Details:		

Destructive Behavior	**Yes**	**No**
Toward property	◯	◯
Stealing	◯	◯
Fire setting	◯	◯

Running	**Yes**	**No**
From home	◯	◯
From programs	◯	◯
Legal charges	◯	◯
Details if yes:		

Probation	◯	◯
GPS Monitoring	◯	◯

Date/Time of Scheduled Admission:

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

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

***Primary Care Provider:**	Practice:
Address:	
Fax:	Phone:
***School Name:**	District:
School Contact:	Email:
Address:	Phone:
DCF:	DCF Office:
Address:	Phone:
Probation Officer:	Court District:
Address:	Phone:
DYS:	
Address:	Phone:
DMH:	
Address:	Phone:
Clinician:	Practice:
Address:	Phone:
Therapist:	Practice:
Address:	Phone:
Psychiatrist:	Practice:
Address:	Phone:
***Preferred Pharmacy:**	
Address:	Phone:
Other:	Relationship:
Address:	Phone:

*Required

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