Abelarde PSYCHOTHERAPY, INC.

450 Pearl Street, Suite 3
Stoughton, MA 02072

REFERRAL LINE: (339) 364-0081 * FAX: (949) 561-5648

Referral for In-Home Therapy Services

Date Intake Completed:
Dates of outreach attempts:
Date of First Appt Offered:
Referral Status:

Referral for In Home Therapy (IHT) _____ or Therapeutic Mentoring (TM) _____ (if TM, please attach the CANS, Comp assessment, safety plan and most recent treatment plan)
How did you hear about our service?
Has the family been served by Abelard Psychotherapy & Associates in the past?

Have you spoken to the family about our services and how they might be useful? Please note date of outreach to the family.

Referral Date: / / Completed by:

Referral By: Agency Name: Contact #:

If referred from a 24 hour facility or residential program, date of anticipated discharge from facility:

Youth Name: Youth Date of Birth: Age:

Youth email address if 14 and OVER: Language(s) spoken at home:

Race & Ethnicity: (if known; Providers will gather directly from the family at intake):

Does the youth currently hold a mental health diagnosis?

Is the youth taking any medications?

Name of prescriber: Agency/Practice name: Contact #:

Name of Primary Care Provider/Pediatrician: Practice Name: Contact #:

Who has legal custody of the youth?

If DCF has legal custody,
Name of ongoing social worker: Area Office:
Contact #: Email: Address: City: , MA Zip code:

Primary Parent / Caregiver Name: Phone #: Email:

Address: City: , MA Zip code:

Other Parent/ Caregiver Name: Phone#: Email:

Address: City: , MA Zip code:

Where does the youth reside and with whom?

Are there scheduling needs that we should be aware?

Primary Insurance: Subscriber: Policy #:

Secondary Insurance: Subscriber: Policy #:

In the home: Animals: Y N Type: Weapons: Y N Are they secured? Y N Smoking: Cigarettes Y N Marijuana Y N Other Substance Y N

Are there other CBHI providers involved (ICC, FS&T, IHBS, TM, mobile crisis) or other therapists (outpatient, ABA, other)?

Name: Agency: Role: Phone #:

Name: Agency: Role: Phone #:

Is the family/youth currently involved with any state agencies that we can partner with (e.g. DCF, DMH, DPH, CSEC, probation, etc.)?

Name: Role: Phone #:

Name: Role: Phone #:

Is there current legal involvement?

What are the identified strengths for the referred youth and family? What are the concerning behaviors present for the referred youth? How might the child's caretaker(s) benefit from the services provided? What are the specific needs they may have?