**NFI Massachusetts Referral / Screening Sheet**

**Referral Information**

Contact Name: Agency/Affiliation:

Address:

Contact Phone: (1) (2) Contact Fax:

**Client Information**

Client Name *(alternative spellings, name on Masshealth card)*:

Gender: Race: DOB:

Address: City: State: Zip:

Phone (Home): Phone (Cell): Phone (Other):

Email Address(es):

School: Grade: School Contact: Phone:

Does the Client have any involvement with a State Agency? YES / NO If YES, circle: DMH DYS DCF

Is family aware of the referral? YES / NO (if no, family must be informed by referral source prior to scheduling intake)

**Client Medication(s):**

**Primary Language of Client:** **Primary Language of Family:**

**Parent/Guardian Information**

Guardian Name (if minor and not parent): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: Phone (home): Phone (work/cell):

Parent Address:

Parent Name: Phone (home): Phone (work/cell):

Parent Address:

**Mental/ Behavioral Health Service Requested**

[ ]  In Home Therapy [ ]  Therapeutic Mentoring

Reason for Referral:

Goal of Treatment/ Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Diagnosis/Code:

Axis I: Axis II:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis IV:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis I:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis III:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GAF:\_\_\_\_\_\_\_\_\_

*For Therapeutic Mentoring Only:*

* Is there an ICC or CSA currently involved in the case? YES / NO Details:
* Is there an Authorized Treatment Plan/Care Plan that recommends therapeutic mentoring? YES / NO

**Insurance Information (Please note we only accept tufts and mbhp)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Type of Insurance** | **Policy Holder** | **Policy #** | **RID#** | **Contact Name/Phone** | **Authorization #** | **Authorization Period** | **#Authorization Units** |
| **PRIMARY** |  |  |  |  |  |  |  |  |
| **SECONDARY** |  |  |  |  |  |  |  |  |

**Additional Information Needed Upon Referral**

[ ]  Care Plan / Tx Plan reflecting requested services

[ ]  Most recent CANS

[ ]  Comprehensive Assessment

[ ]  Risk Management / Safety Plan

**Comments** (*upcoming meetings/appointments*):

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**Background Information**

**Client and Family Background Information**

Any Experience with NFI Services? YES / NO

*If yes, explain*:

Background Information on Child (including strengths and needs):

Is Client Suicidal? YES / NO / Past Hx If yes or past history, describe:

Is Client Homicidal? YES / NO / Past Hx If yes or past history, describe:

**Treatment History** - *Has Client been hospitalized in the Past? Placed out of Home?*

Other Providers Currently Serving Family:

**Client Home Information**

Who is in the Home?

Is there any history of violence or abuse? YES / NO If yes, describe:

Are there weapons in the Home? YES / NO If yes, describe:

Are there pets in the Home? YES / NO If yes, describe:

Description of Neighborhood/Parking, etc:

**Medical Necessity Criteria Met**

Please check any of the following that apply:

[ ]  Is the client displaying severe behavioral problems? [ ]  Has the client not been able to benefit from therapy?

[ ]  Is the client experiencing persistent behavior problems? [ ]  Have traditional treatment approaches not been effective for the client?

**Please send Completed form to** **nfiservices@nafi.com** **or fax to 978-532-0349**

**Questions please contact 978-373-1181 ext 112**

 **\*\*IF THIS IS URGENT PLEASE CONTACT FOUNDATIONS ABOUT SERVICES BY PHONE\*\***