**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*):

**NFI Massachusetts Referral / Screening Sheet**

**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**](mailto: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\*\***