



In Home Therapy Services Referral Form

Phone: (781) 395-0704 Fax: (781) 395-0198

Date of Request for IHT Services: ___/___/___

Insurance (Please check one)

Network Health ___ NHP/ Beacon Health Strategies ___ MBHP ___ Authorization #: _____

Please Note If client is receiving CSA services, authorization is required PRIOR to sending IHT this referral form.

Member Name: _____	Member ID#: _____
D.O.B: ___/___/___	Social Security#: ___ - ___ - ___
Address: _____	
Home Phone: _____	Cell Phone: _____
Legal Guardian/ Custodian Name: _____	Primary Language: _____
Are there any special language/cultural/medical needs for this family? ___Y___N If yes, please explain: _____	

Referring agency: _____	Address: _____
Referring clinician: _____	Phone: () ___ - ___ Fax: () ___ - ___
Date of admission to current facility: ___/___/___	Date of expected discharge: ___/___/___
Does the family understand and agree to work with IHT? ___Y___N	
Parent/Guardian Signature _____	

Brief summary of assessment/treatment: _____

Presenting Problem: _____

Outstanding 51A's filed with DCF: ___Y ___N If yes, please explain: _____

Current support system/agency involvement:

Agency/Provider Name	Contact Person	Office Address	Phone Number	Type of Services/Frequency
Outpatient Therapist				
Psychiatrist				
PCP				
DCF				
DMH				
Other				

Medications:

Name of Medication	Dose	Frequency	Prescribing Physician	Compliant (Y/N)

Diagnosis: (include DSM-IV-TR code)

AXIS I: _____ AXIS II: _____

AXIS III: _____ AXIS IV: _____

AXIS V: _____

Please also attach to this document a copy of the following if available:

Assessment: _____
Treatment Plan: _____
Discharge Summary: _____

Signature of referring Provider: _____

Date: _____

For information, please contact
Program Director
In Home Therapy Services
Eliot Community Human Services
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