UMass Memorial Health
COMMUNITY HEALTHLINK

Please fax back to (508) 860-1245 or email to MYRreferral@communityhealthlink.org

MYR SCREENING / REFERRAL FORM

Date: _____ **Time of referral being sent:** _____

How did you hear about our program? _____

DEMOGRAPHICS:

Client Name: _____
Youth's Current Living Situation: _____
Client's Street Address: _____ **Apt#:** _____
Town: _____ **State:** _____ **Zip Code:** _____
Client Phone: _____ **Social Security #:** _____
Gender Identity: _____ **Pronouns:** _____
Date of Birth: _____ **Age:** _____
City/State of Birth: _____
Race: _____ **Ethnicity:** _____
Primary Language: _____ **Need for interpreter services:** ☐ **None** ☐ **Child** ☐ **Guardian**

GENERAL REFERRAL FORM:

Who is referring client to MYR? Name: _____
Relationship or role to client: _____ **Contact Number:** _____

Do you understand the MYR does not take Section 12s? ☐ **YES** ☐ **NO**
Is there a Section 35 in Place? ☐ **YES** ☐ **NO**

Legal Guardian Name: _____ **Relationship:** _____
Guardian Phone: Home: _____ Cell: _____

Legal Guardian Name: _____ **Relationship:** _____
Guardian Phone: Home: _____ Cell: _____

Mass Health Insurance: ☐ **YES** ☐ **NO** **Mass Health Card #:** _____
Mass Health Plan: (Please specify) _____
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 copy to referral

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 Known Use	History of Overdose
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO

Describe any current psychiatric symptoms or mental health diagnosis:

Describe any past treatment for substance abuse or mental health:

Placement	Inpatient/Outpatient	Dates Attended	Completed?
	☐ IN ☐ OUT		☐ YES ☐ NO
Reason:			
	☐ IN ☐ OUT		☐ YES ☐ NO
Reason:			
	☐ IN ☐ OUT		☐ YES ☐ NO
Reason:			
	☐ IN ☐ OUT		☐ YES ☐ NO
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		
Restricting	☐	☐
Overeating	☐	☐
Bingeing/Purging	☐	☐

Aggression/Violence	Yes	No
Towards family	☐	☐
Towards peers	☐	☐
Towards others	☐	☐
Details:		
Destructive Behavior		
Towards property	☐	☐
Stealing	☐	☐
Fire setting	☐	☐

Running	Yes	No
From home	☐	☐
From programs	☐	☐
Legal Charges	☐	☐
Details if yes:		
Probation	☐	☐
GPS Monitoring	☐	☐

Comments:

****PLEASE INCLUDE ALL PHONE NUMBERS, ADDRESSES, FACILITY NAMES, 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 INFORMATION**

Medical Issues:

Allergies:

Current Medications:

Antipsychotic medications? ☐ **YES** ☐ **NO**

If in DCF custody, was a Rogers obtained? ☐ YES ☐ NO Copy of Rogers provided? ☐ YES ☐ NO

Who will be transporting the client? _____

A legal guardian must sign a minor into the program.

Who will sign legal paperwork? _____

Is the client willing to come to treatment? ☐ **YES** ☐ **NO**

****MYR is a voluntary program. <u>The client must be willing to admit to the program.</u>**

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 stepping down from 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 beneficial for admission
- ☐ Any documentation or information regarding any medical condition
- ☐ **Copy of Insurance Card**

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COMMUNITY HEALTHLINK

Motivating Youth Recovery
26 Queen Street, 5th Floor
Worcester, MA 01610
Main Number: (508) 860-1244

Program Director
Ashley Williams, LCSW
Direct Line: (508) 438-5648

Updated 01/28/2024