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Real Life. Real Support.

Mental Health Association, Inc.
BestLife Clinic Referral Form

COUNSELING RECOVERY COACH
COMMUNITY SUPPORT PROGRAM (CSP)
PARENTING GROUP

MEDICATION REVIEW (PSYCHIATRY)
ANGER MANAGEMENT GROUP
DAY TREATMENT PROGRAM

Referral Source:

Referral Contact Person:

Referral Contact Telephone:

Contact Fax:

Referral Contact Email Address:

Name:

Other/Preferred Names:

Gender:

Gender Identity:

Sexual Orientation:

Pronouns:

Date of Birth:

Social Security Number:

Ethnicity (select one):

Race (select one):

Preferred Spoken Language:

Preferred Written Language:

Address (Street):

(City, State, Zip Code):

Telephone Number:

Email Address:

Emergency Contact:

Name:

Address:

Relationship:

Telephone Number:

Allergies: *(If any, please specify symptoms)*

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Primary Concerns of Individual Being Referred (i.e. sadness, anxiety, depression, alcohol or substance use):

Assessed Needs Identified for CSP Services (This information, as well as a copy of a fully completed biopsychosocial Comprehensive Assessment and a signed Authorization to Release Information form, are required in order to accept the referral):

- Assisting Member in enhancing their daily living skills
- Providing service coordination and linkage
- Assisting with obtaining:
Benefits Housing Health Care
- Developing a Crisis Plan
- Providing Prevention and intervention services
- Fostering empowerment and recovery
- Linkage to peer support or self help groups
- Transportation to essential appointments
- Other, please specify:

DSM-5-TR and Medical Diagnoses:

Psychiatric Hospitalizations/Inpatient Detoxifications: When?

Where?

Primary Care Provider:

Name of Practice/Office:

Office Telephone:

Clinician's Name:

Date of Last Visit:

Insurance Information: (This information, as well as a copy of the patient's medical insurance card(s), are required in order to accept the referral):

Insurance Carrier (i.e. Tufts, MassHealth, Medicare):

Insurance Number:

Subscriber Name (if other than "Self"):

- Subscriber Date of Birth:
- Relationship to Subscriber:

****Please feel free to submit this referral by any of these options listed below****

Email: bestlife@mhainc.org

Fax: 413-737-7949

If you have any questions or need any assistance in completion of this referral please phone the main line at **1-844-MHA-WELL**. Option 1 will connect you with our Central Intake Department who will be helpful in scheduling and answering any questions that you may have about our referral process.

Thank you so much for this referral!