

OUT AT HOME REFERRAL

TODAY'S DATE:



PLEASE FILL IN ALL THE INFORMATION BELOW. AREAS LEFT BLANK WILL NEED TO BE FILLED IN BEFORE A REFERRAL CAN BE PROCESSED. ONCE COMPLETED, E-MAIL TO OUTATHOMEINTAKE@THEHOME.ORG WITH A COPY OF INSURANCE CARD.

Individual therapy ☐	Group therapy ☐	Family therapy ☐	Couple's therapy ☐
Are you seeking therapeutic services as part of a court-ordered agreement? Yes ☐ No ☐			
If "yes," please explain:			
Are you open to treatment by a final year MA level intern? Yes ☐ No ☐			
Person Referred for Services (for family or couple's counseling, put name of individual whose insurance will be used)	Name Used:	Date of Birth:	Gender Identity:
	Pronouns:		
	Name on insurance card:		
	Sex on insurance card:		
Sexual Orientation:		Sex Assigned at Birth:	
Some people are labeled male or female at birth and are born with anatomy/genetics that might fall outside of a medical binary. Do you use words like intersex to describe yourself?			
Ethnicity (Country of Origin):		Race:	
Name of Caretaker(s) (if client is under 18) OR Emergency Contact name and phone number in case of medical issue for adult client:		Caretaker(s)/Emergency Contact Relationship to Client:	
		Caretaker(s)/Emergency Contact Pronouns:	
If client is under 18, who has legal and physical custody?			
Address:			
Preferred Phone No:		Back up/Alternative Phone #:	
Email address (if applicable):			
Language(s) spoken and preferred language for services:		Other important cultural considerations/factors:	
What is your location preference for services (select all that apply): ☐ Telehealth (video preferred for Out at Home) ☐ Neponset Ave, Dorchester ☐ E. Dedham St, Boston ☐ Somerville		What days and times are you available to meet for a session? Please note Out at Home operates Monday-Friday.	
School (if applicable):		Health Center/PCP: Gender clinic (if applicable): Psychiatrist (if applicable): Any other providers (i.e: In Home Therapy, Family Partner, Mentor, etc):	
Current list of medications and who currently prescribes medication:			

REFERRAL SOURCE	Individual's name:	Role with Family/Agency:
Phone:	Fax No:	Other Contact Info:

INSURANCE INFORMATION	Plan Name/ID #:	For MassHealth- MMIS #:
Please attach a picture of your insurance card with referral.		
Current Diagnosis/Diagnoses and ICD9 code:		
Who generated diagnosis and when?		

What are the current concerns or behaviors for the identified family member that led you to call us?
What has been helpful for the individual/family currently or in the past? What are their strengths?

ADDITIONAL INFORMATION- REQUIRED

FOR ALL SECTIONS BELOW, PLEASE CHECK APPROPRIATE BOXES ALONG SIDE		
TOPIC	CURRENT	PAST
SUBSTANCE USE	☐	☐
GAMBLING	☐	☐
DISORDERED EATING	☐	☐
SELF-HARM	☐	☐
SUICIDAL IDEATION	☐	☐
SUICIDE ATTEMPT	☐	☐
SEEING/HEARING THINGS OTHERS DO NOT SEE/HEAR	☐	☐
GANG INVOLVEMENT	☐	☐
AGGRESSIVE/VIOLENT BEHAVIOR	☐	☐
LEGAL CHALLENGES	☐	☐
PSYCHIATRIC HOSPITALIZATION	☐	☐
CBAT/PARTIAL HOSPITALIZATION	☐	☐
FIRE-SETTING	☐	☐
CRUELTY TO ANIMALS	☐	☐
OTHER (please include anything you feel would be helpful for us to know that is not included above)		

FOR ALL SECTIONS BELOW, PLEASE CHECK APPROPRIATE BOXES ALONG SIDE			
TOPIC	CURRENT	PAST	NEVER EXPERIENCED
HAVE YOU/YOUR CHILD EVER FELT LIKE YOU ARE NOT ACCEPTED BY PEOPLE IN YOUR LIFE (LOVED ONES, PEERS, COLLEAGUES, CLASSMATES, ETC?)	☐	☐	☐
HAVE YOU/YOUR CHILD EVER FELT LIKE OTHERS DO NOT HAVE AN UNDERSTANDING OF ONE OR MORE ASPECTS OF YOUR/THEIR IDENTITY?	☐	☐	☐
HAVE YOU/YOUR CHILD EVER FELT LIKE YOU DO NOT HAVE A SENSE OF BELONGING WITH THOSE AROUND YOU AND/OR A COMMUNITY YOU/THEY ARE A PART OF?	☐	☐	☐
HAVE YOU/YOUR CHILD EVER FELT LIKE YOU/THEY HAD SOMEONE IN YOUR/THEIR LIFE THAT WAS AFFIRMING AND SUPPORTIVE OF YOUR/THEIR IDENTITY?	☐	☐	☐
HAVE YOU/YOUR CHILD EVER FELT LIKE YOU/THEY HAD A PROVIDER WHO WAS AFFIRMING AND KNOWLEDGEABLE ABOUT YOUR/THEIR IDENTITY AND NEEDS?	☐	☐	☐