River Valley Counseling Center

CLIENT #:_____

Therapeutic MENTORING Request Form

Date of Referral:_____ Language Spoken at Home:_____ Gender:_____

Name of Child:_____ D.O.B.:_____ Age:_____

Address:_____ City:_____ Zip:_____

Phone Number(s):_____

PARENT or GUARDIAN (name and rel'n):_____

Custody Status (Who signs releases?):_____

Name of School Child Attends:_____

Referred by (HUB):_____ Agency:_____ Phone #:_____

!!FOLLOWING MUST BE ATTACHED!!

CA:____ TX Plan (with Goals/Interventions for TM):____ Most recent CANS (2's and 3's):____

Release of Info (SIGNED) for Hub:_____

Insurance Information

MMIS Number:_____ Policy #:_____

MBHP:___ MBHP-HNE:___ BMC/Fallon:*N/A @ this time* Tufts:____

Needs/Skills to be addressed by Mentor:

___ Emotional regulation **Give examples:_____**
Communication _____
Conflict Management _____

___Social skills _____
Age-appropriate peer interaction _____

___Self-esteem/self-worth/self-image _____

___Impulse control/activities to redirect high levels of energy _____

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___**Cognitive Skills** _____

___**Transitional Age Skills** _____

****PLEASE FAX TO 413-594-1912 or scan and email to: lavallee_natalie@holyokehealth.com****

CBHI Coordination Only

Received:_____ **Assigned date:**_____ **Assigned To:**_____

1st Contact:_____ 2nd Contact:_____ 3rd Contact:_____

First DOS:_____ **Discharge Date:**_____