River Valley Counseling Center

# Project SOAR (Skills, Opportunities, and Recognition) Referral Form

Date of referral:_____ Language(s) Spoken at Home:_____ Gender: _____

NAME of Youth/Client:_____ D.O.B.: _____

Address:_____ City:_____ Zip: _____

Youth/Client Phone:_____ Parent/Caregiver Phone: _____

Parent/Caregiver Name:_____ Relationship: _____

Referred by:_____ Agency:_____ Phone: _____

Custody Status:_____ *If applicable* DCF Worker Name:_____ Phone: _____

## Insurance Information

MMIS Number:_____ Policy Number: _____

Insurance Carrier:_____ Social Security Number: _____

## Reason for Referral:

Project SOAR (Skills, Opportunities, and Recognition) is a brief mentoring intervention for Holyoke High School students with concern for at-risk behaviors. Project SOAR is a minimum of 4-6 sessions, and includes the opportunity for students to be referred to appropriate follow up programs, including A-CRA at River ValleyCounseling Center. Please describe this student's interest in participating in Project SOAR:

_____

_____

_____

_____

_____

Symptoms being demonstrated (anxiety, depression, anger, risk to self/others, substance use):

_____

_____

_____

_____

Is the youth at risk of being removed from the home: ☐ Yes ☐ No
If yes, please explain: (hospitalization, DCF removal, residential placement):

_____

_____

_____

_____

Behavioral issues that are being demonstrated at home/school/community/employment:

_____

_____

_____

_____

Please describe history of treatment for SUD/MH and list all current providers (provide contact information):

_____

_____

_____

_____

**Areas covered by RVCC Project SOAR Team:** Holyoke

******Please fax completed referral form to Central Intake (413)534-2889***Attention: Christine Saraceno***

***(413)-377-6303***

***saraceno_christine@holyokehealth.com***

**Project SOAR Coordination Only**

**Date Received:_____Assigned date:_____Assigned to:_____**

**Intake Date:_____**

**Date of 1st Contact:_____Date of 2nd Contact:_____Date of 3rd Contact:_____**

**Date of 4th Contact:_____Date of 5th Contact:_____Date of 6th Contact:_____**

**Discharge Date:_____**



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