



River Valley Counseling Center

W.I.S.E: Wellness Interventions Support and Education Referral Form

Date of referral: _____ Language 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: _____

Name of school youth attends: _____

Insurance Information: (If known)

MMIS Number: _____ Policy Number: _____

Insurance Carrier: _____ Social Security Number: _____

Reason for Referral:

The Wellness Interventions Support and Education program is a present-focused intervention that teaches coping skills to help children ages 8-13 attain safety from trauma and/or substance use. Students who may be appropriate include, but are not limited to: *poor school attachment, poor academic performance, truancy, IEP/504, Individual Substance misuse (including vaping), family history of SUD (witnessing an overdose), family history of mental health diagnosis, peer group that uses substances or has pro substance views, behavioral attitude, other state agency involvement:* _____

Behaviors observed/reported: (isolation, anger, withdrawal, depression, etc.): _____



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Is youth at risk of being removed from home: **Yes** **No**

If yes, please explain: (hospitalization, DCF removal, residential placement):

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

Please describe if any history of treatment for mental health and list all current providers (provide contact information if available):

Areas covered by RVCC W.I.S.E Team: William R. Peck and Holyoke Middle Schools

*****Please fax completed referral form to Central Intake (413) 538-5169*****

Attention: WISE Intake

(413) 377-6449

rvccWISE@holyokehealth.com

W.I.S.E Staff Only

Date received: _____ **Date assigned:** _____ **Intake schedule date:** _____

Assigned to: _____ **Mentor assigned? Yes No If YES, mentor name:** _____

Date Intake completed: _____ **Date quarterly assessment completed:** _____

Date quarterly assessment completed: _____ **Date quarterly assessment completed:** _____

Discharge Date: _____