River Valley Counseling Center

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

## Adolescent Services Referral Form

**Check off the desired program:**

☐ **iDecide** (Drug Education Curriculum: Intervention, Diversion, and Empowerment): is a (5 hour) drug education curriculum for students at risk of substance use. The program provides behavioral support, psychoeducation, and empowers students to engage in healthy decision making.

☐ **Project SOAR** (Skills, Opportunity, and Recognition): is a brief mentoring intervention (a minimum of 4-6 sessions) that can help students with stress management, setting goals, social pressures and promoting achievement.

☐ **A-CRA** (Adolescent Community Reinforcement Approach): is brief, intensive, evidenced based treatment for 12-24 year olds to support substance use recovery. A-CRA is 10-14 sessions, which includes 1-4 sessions with Parent/Caregiver. Treatment is targeted to support peer connection, education and skill building/practice.

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:

Please describe this student's interest in participating in SOAR programming:

_____

_____

_____

_____

PO Box 791, Holyoke, MA 01041 ● (413) 540-1234 ● Fax (413) 538-5169
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Please circle all factors that apply:

| | | | | |
|---|---|---|---|---|
| anxiety ☐ | risk to self/ others ☐ | Poor academic performance ☐ | Issues with self-control ☐ | Negative peer influence ☐ |
| depression ☐ | substance use ☐ | truancy ☐ | Low ability to manage, regulate, and utilize emotions ☐ | Attention issues ☐ |
| anger ☐ | Exposure to su ☐ | Lack of peer connections ☐ | Family conflict ☐ | Legal involvement ☐ |

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) 538-5169******

***Attention: Project SOAR Intake***

***(413)-377-6450***

***rvccSOAR@holyokehealth.com***

River Valley Counseling Center

**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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