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.): _____

_____

_____

_____

_____

PO Box 791, Holyoke, MA 01041 (413) 540-1234 Fax (413) 538-5169
rvccinc.org
A member of Valley Health Systems, Inc.

River Valley Counseling Center

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:

_____

_____

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_____

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

_____

_____

_____

_____

<u>Areas covered by RVCC W.I.S.E Team:</u> STEM Middle School

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

Attention: WISE Intake

(413) 377-6449

rvccWISE@holyokehealth.com

<u>W.I.S.E Staff Only</u>

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: _____