River Valley Counseling Center

CLIENT #:_____

Therapeutic MENTORING Request Form

Date of Referral: _____ Language Spoken by Client: _____ By Parent: _____

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

Gender (Legal): _____ How Identifies: _____ Pronouns: _____

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: _____ Agency: _____ Phone#: _____

Hub (if diff from above): _____

Hub Email/Phone #: _____

ALL REFERRALS MUST INCLUDE:

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

Release of Info (SIGNED) for Hub: ☐ Therapeutic Risk Screening Tool: ☐

INCOMPLETE REFERRALS WILL NOT BE PROCESSED

Insurance Information

BHCA: ☐

MMIS Number: _____ Policy #: _____

MBHP: ☐ MBHP-HNE: ☐ Wellsense/BMC/Fallon: ☐ Tufts/Healthy Together: ☐

Commercial: Optum: ☐ Other: _____

Goals/Objectives being addressed by HUB:

Page 2

Skills for TM to address:

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

CBHI Coordination Only

Received: _____ Assigned date: _____ Assigned to: _____