

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:

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

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: _____