Children's Friend and Family Services
Referral – Outpatient Therapy

Date of Referral: _____

☐ **Salem:**	☐ **Lynn:**	☐ **Gloucester:**	☐ **Lawrence:**
110 Boston St, Salem	112 Market Street, 2nd Fl,Lynn	33 Commercial St, Gloucester	15 Union St, Ste. 200, Lawrence
p: 978.744.7905	p: 781.593.7676	p: 978.283.7198	p: 978.682.7289
Please fax to: 978.740.9145	**Please fax to: 781.595.1081**	**Please fax to: 978.281.7793**	**Please fax to: 978.686.2954**

Child/Youth Information: Preferred Language: ☐English ☐Spanish ☐Other: _____

Name: _____ **D.O.B:** _____

School: _____ **Grade:** _____ **IEP?** _____

Primary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** _____

Secondary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** _____

Ethnicity: _____ **Gender:** ☐Male ☐Female **SS#:** _____

Psychiatric Diagnosis*: **DSM Code:** _____ **Narrative:** _____

DSM Code: _____ **Narrative:** _____

Who generated dx and when? _____ **PCP:** _____

**Including this information significantly assists in ability to gain authorization for service. Please include when at all possible.*

Medical Conditions/Allergies/Medications:

Service Preferences: ***(Please note: we will accomodate based on clinical appropriateness)***

Best Times/Days to be Seen: _____

Preferred Place(s) to be Seen: ☐ Children's Friend Office ☐ School ☐ Home ☐ Other:

Service(s) Requested: ☐ Individual Therapy ☐ Family Therapy ☐ Couples Therapy

The following evidence-based treatments are offered at CFFS. Please check if you would like us to explore the use of one of these models with the person being referred:

☐**Trauma Focused Cognitive Behavioral Therapy (TF-CBT):**

TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

☐**Positive Parenting Program (Triple P):**

Triple P is one of the most effective evidence-based parenting programs in the world, backed up by more than 30 years of ongoing research. Triple P gives parents simple and practical strategies to help them confidently manage their children's behavior, prevent problems from developing and build strong, healthy relationships.

Parent/Guardian Information: Preferred Language: ☐English ☐Spanish ☐Other: _____

Name: _____ **Ethnicity:** _____

Relationship to Child: _____

Address: _____ **Home Telephone:** _____

Cell Phone: _____ **Other Telephone:** _____

Legal Guardian (☐same as above)**:** _____ **Physical Custody:** (☐same as above): _____

Where does child currently live? ☐With Parent(s)/Guardian(s) ☐Foster Home ☐Group Home ☐Other:

If not with parent(s)/guardian(s) listed above, please give name, address, and telephone number of current residence:

Person Making Referral: **Fax:** _____

Name: _____ **Organization/Agency:** _____

Address: _____ **Work Telephone:** _____

E-mail: _____ **Cell Phone:** _____

Check Level of Care if Applicable: ☐N/A ☐ CSA ☐ IHT ☐ Outpatient ☐ ESP/MCI ☐ CBAT ☐ STARR ☐ Hospital ☐ Other:

Brief description of your concerns and goals in referring child (please include any current safety concerns):

Past/Current Risk Factors: ☐DV ☐Mental Illness ☐Substance Use Disorder ☐Abuse ☐Neglect ☐Medical Issues ☐Cultural Factors ☐Suicidal/Homicidal Ideation ☐ Other: