Winchester Community Mental Health Center, Inc.

AGENCY REFERRAL FORM

**Please include supporting documentation: safety plan, court orders, service plans, consents, etc. **

Failure to provide all requested information on this form may result in a delay in services

****PLEASE EMAIL REFERRALS TO THE EMAIL LISTED BELOW****

From: Date: _____

Agency Name:_____

Agency Staff Name:_____

Telephone:_____ Ext. _____ Fax #:_____

To Agency Coordinator: Sheila Medcalf Wilson
sheilam@wcmhc.com
(Main) 540-535-1112 ext. 144
(Fax) 540-535-1155

Client's Legal Name:_____ DOB: _____

Client's Parent/Guardian Name: _____

Telephone Number:_____

Address: _____

Primary Insurance:_____ Member Number:_____

Insurance Policy Holder Name:_____ DOB:_____

Secondary Insurance:_____ Member Number:_____

Insurance Policy Holder Name:_____ DOB:_____

SERVICES RENDERED BY WINCHESTER COMMUNITY MENTAL HEALTH CENTER

- ☐ Psychiatric Medication Management Program (with Psychiatric Evaluation)
- ☐ Outpatient Counseling
- ☐ Suboxone Program (Medicated Assisted Treatment Program)
- ☐ Adolescent Substance Abuse/Mental Health Intensive Outpatient Program
- ☐ MHIOP- Mental Health Intensive Outpatient Program
- ☐ SAIOP- Substance Abuse Intensive Outpatient Program
- ☐ MHPHP- Mental Health Partial Hospitalization Program
- ☐ SAPHP- Substance Abuse Partial Hospitalization Program
- ☐ Intensive In Home Services {Under 21 years of age}
- ☐ Mental Health Skills Building Services {ADULTS ONLY}
- ☐ Applied Behavioral Analysis
- ☐ Substance Abuse Assessment

SERVICES RENDERED BY WINCHESTER COMMUNITY MENTAL HEALTH CENTER THAT REQUIRE FUNDING

- ☐ Mental Health Assessment
- ☐ Trauma Assessment (child/adolescent or Adult)
- ☐ Specialized Therapy- Trauma Therapy, Attachment Therapy, Child & Adolescent Sex Offender Therapy
- ☐ Parent Mentor Services
- ☐ Intensive Care Coordination & Family Support Partner Services
- ☐ Bridging Natural Supports
- ☐ Virtual Residential
- ☐ L.I.F.E. Program (Independent Life Skills Program)
- ☐ Utilization Review
- ☐ Therapeutic Mentor Services/Therapeutic Tutoring
- ☐ D.A.T.A. Program (Intensive Parent Mentor Services)
- ☐ Attachment/Developmental Assessment {Full Eval or Abridged}

Winchester Community Mental Health Center, Inc.

ADDITIONAL REFERRAL INFORMATION

**Please include supporting documentation: safety plan, court orders, service plans, consents, etc. **
Failure to provide all requested information on this form may result in a delay in services

WHAT IS THE REASON FOR THE REFERRAL?

REASON FOR AGENCY/DEPARTMENT INVOLVEMENT? ANY PRIOR AGENCY/DEPARTMENT INVOLVEMENT?

IS THERE A SAFETY PLAN, PROTECTIVE ORDER, FOSTER CARE PLAN, IEP, OR 504 PLAN? IF SO, WHAT ARE THE LIMITATIONS, SERVICE MANDATES, AND/OR ACCOMODATIONS?

IS THERE COURT INVOLVEMENT? PLEASE INCLUDE NEXT COURT DATE AND REASON FOR COURT

IF FUNDING IS REQUIRED, WHEN WILL THE CASE BE GOING TO FAPT/OTHER FUNDING SOURCE?

PLEASE LIST BELOW THE AGENCY/DEPARTMENT'S GOALS FOR THE CLIENT WHILE IN SERVICES

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. All supporting documentation has been attached and reviewed.

Signature: _____ Date:_____

Winchester Community
Mental Health Center, Inc.

Client Name:

DOB:

SAFETY CONCERNS:

NAME OF CHILD(ren):

SHORT TERM GOALS THAT CLIENT MUST MEET PER AGENCY REQUIREMENT.

1.
2.
3.
4.
5.

LONG TERM GOALS THE CLIENT MUST MEET PER AGENCY REQUIREMENT.

1.
2.
3.
4.
5.

• Goals will be reviewed monthly.