CBHI Referral Form
TJocelyne Counseling & Consulting Group
425 Pleasant Street, First Floor
Brockton, MA 02301
Email to: intake@tjocelyne.org

Phone: 508-580-0364 ext.2

Fax: 1-888-506-6021

Date: _____

Referring Agency/facility_____

Name of person completing form_____

Address_____ Phone_____

Referred Client/Patient Information

MMIS#_____

First Name_____ Last Name_____ DOB_____
Age_____ Gender_____ Preferred Pronouns _____

Home Address_____City_____
Zip Code_____ Cell number_____ Work number_____

Preferred Language _____ Ethnicity/Race_____

Email_____
_SSN_____

Primary Insurance Provider (circle one) BEACON – MBHP – TUFTS – NHP

Other: _____

Insurance ID_____

Secondary Insurance Provider_____

Insurance ID_____ Phone number_____

Legal Guardians
Name_____

Address of Guardian_____ City_____

Zip code_____

Clinician Preference: Woman or Man Language_____

Reason for Referral: (circle one)

In Home Therapy, Therapeutic Mentor(TTS), Behavioral Services, Outpatient

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Presenting Problem/Concern

_____

_____

_____

_____

DYS/DMH/DCF/DDS Workers Involved? (circle one) Y N

Psychiatrist/ Prescirber_____

Phone_____

Diagnosis_____

TJOCELYNE COUNSELING & CONSULTING LLC OFFICE USE ONLY

Provided a copy of the Safety Plan & Comprehensive Assessment? Y N

Provided a copy of the CANS & Treatment Plan? Y N

Phone & Correspondence Log

DATE	*ACTION*	*RESULTS*

TJCC Representative:_____Cell #_____

Authorization_____ Units_____

Clinicians Assigned_____

Date Intake is accepted by Clinician_____ Date of scheduled appt._____