

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/ Prescriber _____

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.* _____