TJocelyne Counseling and Consulting Clinic
General Referral Form for Adults

(Please fill out this referral completely. Contact us at (508) 580-0364, to submit via email at intake@tjocelyne.org or fax at (888)506-6021.

CLIENT INFORMATION

Name: _____ Gender: _____ DOB: _____/_____/_____ Age: _____

Social Security #: _____/_____/_____ MMIS #: _____ Phone #: (_____)_____-_____

Payer Type: ☐ MBHP ☐ BMC ☐ ☐ Private/Other Policy #: _____

Contact/Guardian Name: _____Relation to Client: _____ Phone #: (_____) _____ -_____

Address: _____ Town: _____ Zip:_____

Members of Household: _____

Primary Language: _____ Secondary Language:_____

Email:_____*Required

REFERRER INFORMATION

Referral Name, Agency & Phone #: _____

DCF Worker Name, Office & Phone #: _____

Availability: ☐ Daytime ☐ Afternoon ☐ Evening ☐ Weekday ☐ Weekend ☐ Other: _____

Is client willing to engage in telehealth services? ☐ Yes ☐ No

Prior/Current Treatment or Services:
Axis 1 Diagnosis:

Other Providers

Provider	*Name*	*Phone Number*	*Agency*
Substance Use Counselor			
Psychiatry			
Therapist			
Other			

Significant Impairment in Functioning: ☐ Home ☐ Work ☐ Relationships ☐ Other/Legal/Community: _____

Reason for Referral *(Please specify the level of care desired or suggested, i.e., Individual Therapy-Telehealth/Face to face, Couple Counseling, Psychopharmacology:*

RISK FACTORS OR SAFETY CONCERNS

Check All that apply:

☐ Suicide Ideation	☐ Suicide Gestures	☐ Self-Injurious Behavior	☐ Homicidal Ideations	☐ Current Substance Use
☐ History of Substance Use	☐ Impulsive Behavior	☐ Violence/Aggression Towards Others		☐ Lack of Social Group
☐ Gang Involvement	☐ Sexualize Aggression/Behavior	☐ Takes Dangerous Risks	☐ Fire-setting	☐ Work Impairment/loss
☐ Isolation Behavior	☐ Trauma History	☐ Medical/Physical Issues	☐ Compulsive behavior	☐ Not Medication Compliant
☐ In-Home Issues	☐ Lack of Natural Support	☐ Housing Instability	☐ Mental Health Diagnosis: _____	
☐ Other:				

CAREGIVER RISK FACTORS

Primary Support's Risk Factors:			
☐ Current Substance Use	☐ History of Substance Use	☐ Not Medication Compliant	☐ Housing Instability
☐ Financial Distress	☐ Current Domestic Violence	☐ History of Domestic Violence	☐ Mental Health Diagnosis
☐ Medical / Physical Issues	☐ Unable/Unwilling to Provide Natural Supports	☐ Lack of Natural Supports	
☐ Other:			

Please provide any additional information that may be relevant to assist us in meeting your needs and those of your partner. If you are seeking couple or marriage counseling, please provide demographic information about your spouse/partner.