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| **Intake form:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | |  | | |
| **Services:** | | | **❑in home outpatient** | | | | | | | | | **❑Outpatient** | | | | | | | | **❑CSP** | | **❑ OTHER** | | | | |  | | | | | | | | | | | | | | | | | |
| **Method:** | | | **Phone** | | | **Fax** | **Agency: EOPC Dedham OFFICE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | **probation: Adult Juv** | | | | | | | | | |
| **Referral source:** | | | | | |  | | | | | | | | | | **agency:** | | | |  | | | | | | | | | | | | | **phone#:** | | | | | | | |  | | | |
| **Consumer Information: (1st Name) (last name)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | **Sex:** | | | | | **❑Male** | | | | | **❑ Female** |
| **Current address:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Apt #:** | |
| **City:** |  | | | | | | | | | | | | | **State:** | | | |  | | | | | | | | | | | | **ZIP Code:** | | | | | | | | | |  | | | | |
| **Date of Birth:** | | | |  | | | | | | | | | | **S.S #:** | | | |  | | | | | | | | | | | | | **Age:** | | | | | | |  | | | | | | |
| **Ethnicity:** | |  | | | | | | | | | | | | | | | | | | **Language Spoken:** | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Best phone #:** | | | |  | | | | | | | | | | | | | | | | **Secondary phone#:** | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Emergency Contact (Name):** | | | | | | | |  | | | | | | | | | | | | | | | | | **Emergency (phone #)** | | | | | | | | | | | | | |  | | | | | |
| **Parent/Guardian (18 & under):** | | | | | | | | | |  | | | | | | | | | | | | | | | | **Current School:** | | | | | | | | | | | |  | | | | | | |
| **Insurance Information** | | | | | | | | | | | | | | **Member Insurance ID:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **❑ MBHP** | | | **❑NHP** | | | **❑BMC** | | | **❑BC/BS** | | | | **❑Medicare** | | | | | | **❑Celticare** | | | | | **❑Tufts/Network** | | | | | | | | | | | | **❑ Other:** | | | | | | | | |
| **Reason for referral (Presenting Issue):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Clinical Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Does client have outpatient services? -YES -NO N/A (if yes)**  **(Name) (Agency) (Contact #)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is Client currently: Suicidal Yes No N/A OR Homicidal Yes No N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is client currently Hospitalized? : Yes No Where?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Requested current treatment plan/goals from provider?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is client in a dangerous situation? : Yes No (If yes, follow emergency protocol)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have they ever been a victim of violence or crime in the past? YES NO N/A**  **Is this impacting/affecting your decision to come to counseling? YES NO Incident? :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have they ever tried to quit using a substance? YES NO N/A**  **Cigarettes Alcohol Drugs (type):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Disposition (Administrative use only)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Accepted for service-appointment** | | | | | | | | | | | **Date:** | | | | | | | | | | | | | | | | | | | | | **Time:** | | | | | | | | | | | | |
| **Assigned Provider(s):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referred elsewhere? Yes NO IF yes, why?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Waiting list date:** | | | | | | | | | | | | **Informed referrer date:** | | | | | | | | | | | | | | | | | **Informed family date:** | | | | | | | | | | | | | | | |
| **Final Disposition: Assigned Referred Out Unassigned (closed out)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Returning Consumer? Yes No** | | | | | | | | | | | | | | | | | **MIS #:** | | | | **\*\*Contact Referral & Document all contact in notes. \*\*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Notes (Additional information)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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