



MENTAL HEALTH ASSOCIATION
FIND WELLNESS.

320 North Goodman St.
Rochester, NY 14607
Office: 585-325-3145 x 152
Email: mhafsreferral@mharochester.org

MHA Rochester
Referral for Children and Family
Treatment and Support Services
(CFTSS)

MHA Office Use Only:

Date Received by: _____
Date Logged In by: _____
Date Approved by: _____
Date Referred Out: _____

Client ID: _____

REFERRAL DATE: _____

CLIENT INFORMATION:

First Name: _____ Mid. Init: _____		D.O.B.		Policy #/CIN:	
Last Name: _____		City:		State:	Zip Code:
Current Street Address:		Mobile Phone:		Work phone:	
		Home Phone:			
Residence Type (private, group home, etc.)		E-mail address:			
Default Communication Method: <input type="checkbox"/> Home email <input type="checkbox"/> Home phone <input type="checkbox"/> Mail <input type="checkbox"/> Mobile phone call <input type="checkbox"/> Mobile phone text <input type="checkbox"/> Work email <input type="checkbox"/> Work phone		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other			
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Biracial <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		Additional Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Biracial <input type="checkbox"/> Other	
Primary Language: <input type="checkbox"/> English only <input type="checkbox"/> American Sign Language (ASL) <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish only <input type="checkbox"/> Bi Lingual <input type="checkbox"/> Other		Interpretation/Translation Needs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Parent can interpret English writing <input type="checkbox"/> Parent can interpret Spanish writing Other			



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CHILD INSURANCE INFORMATION (1):

Insurance ID No.:	Date Insurance Effective:
Insurance Provider/MCO:	

CHILD INSURANCE INFORMATION (2):

Insurance ID No.:	Date Insurance Effective:
Insurance Provider/MCO:	

PARENT OR GUARDIAN CONTACT:

Name:	Relationship to Client:	
Date of Birth:	Transportation: Yes	No
Phone (Day):	Address:	
Phone (Evening):	City:	Zip:
Does the parent/caregiver have access to transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No What type? <input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Other _____		
Are there any special needs for transportation? If yes, please explain (i.e. wheelchair access, etc.):		

CHILDS INFORMATION (1):

Primary Diagnosis (ICD-10):	Environmental Stressors:
Secondary Diagnosis (ICD-10):	Functional impairment:
Medical Conditions:	SPMI? <input type="checkbox"/> Yes <input type="checkbox"/> No
Symptomatic Behaviors:	
Does client have any physical limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe	
Does client take medication(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list:	
Are there any side effects we should be aware of?	
Current involvement in treatment and programs (e.g. therapy, day-treatment, volunteering, and recreation) - please list:	



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CHILDS INFORMATION (2):

Primary Diagnosis (ICD-10):	Environmental Stressors:
Secondary Diagnosis (ICD-10):	Functional impairment:
Medical Conditions:	SPMI? Yes No
Symptomatic Behaviors:	
Does client have any physical limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe	
Does client take medication(s)? Please List them: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any side effects we should be aware of?	

REFERRING AGENCY CONTACT INFORMATION

Referring Provider:		Title:	
Agency:			
Address:		City:	Zip:
Phone (Required):	Fax:	Email (Required):	
Preferred Method of Contact: <input type="checkbox"/> E-mail <input type="checkbox"/> Mail	Relationship/role with client:		Type of treatment:

Health Home Care Coordinator:		Title:	
Agency:			
Address:		City:	Zip:
Phone (Required):	Fax:	Email (Required):	
Preferred Method of Contact: <input type="checkbox"/> E-mail <input type="checkbox"/> Mail	Relationship/role with client:		Type of treatment:

Other Provider:		Title:	
Agency:			
Address:		City:	Zip:
Phone (Required):	Fax:	Email (Required):	

Other Provider:		Title:	
Agency:			
Address:		City:	Zip:
Phone (Required):	Fax:	Email (Required):	



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Recommended Family Support Service(s): *Check all that apply:*

Rehabilitative Service	Description of needed intervention
Family Peer Support Services	<input type="checkbox"/> Engagement, Bridging, and Transition Support <input type="checkbox"/> Self-Advocacy, Self-Efficacy and Empowerment <input type="checkbox"/> Parent Skill Development <input type="checkbox"/> Community Connections and Natural Supports <input type="checkbox"/> Education Advocacy <input type="checkbox"/> Support Groups <input type="checkbox"/> Family Education Workshops
Additional information:	