	Abelard Psychotherapy IHT and TM Referral Form				
To make a referral, call 339-364-0081 or fax to 781-344-0027 or email to CBHIDirector@Abelardinc.com					
Primary Insurance					
Secondary Insurance					
Priority Status	Is this referral from a 24 hr facility or mobile crisis?			_____Yes	_____No
Service requested	_____IHT	_____TM			
NAME of Youth					
DOB		*If 14 or older, email:*			
Home address			Town:		Zip:
Who lives in home?					
Race/ethnicity		*Language preference:*			
Legal Guardian(s):			***Other caregiver(s):***		
Address if different			*Address if different*		
Phone #			*Phone #*		
Guardian email			*Email*		
Referral Source					
Referral agency			Phone number:		
Date of referral					
Referral completed by	(Abelard staff):				
Reason for referral					
Animals in the home?	____No	____Yes; type(s):			
Weapons in home?	____No	____Yes; type(s):			
Smoking in home?	____No	____Yes; type(s):			

Health/Medical					
Mental health Dx?					
Medications?					
Medical Dx?					
School / grade			_____IEP	_____504	
scheduling needs					
Collateral providers	name	agency	phone #	email	
Pediatrician / PCP					
Psychiatrist/Prescriber					
DCF (not legal guard)					
ICC					
Family Partner					
TM					
Outpatient therapist					
IHT					
IHBS					
ABA					
Before/After school					
Probation (CRA)					
Other:					