Volunteers of America of Massachusetts (VOAMASS)
Residential Rehabilitation Services (RRS) Referral Form

Date of referral: _____

I am making a referral to:

☐ Men's Hello House - Mass Ave (co-occurring enhanced RRS for mental health and SUD)
☐ Men's Hello House - Burt Street (co-occurring enhanced RRS for mental health and SUD)

☐ Women's Hello House (co-occurring enhanced RRS for mental health and SUD)
☐ Women's Shiloh House (co-occurring enhanced RRS for mental health and SUD)

CLIENT INFORMATION

Name: _____
Phone number and email address: _____
Date of birth: _____
Social security number: _____
Preferred pronouns: _____
Are you Hispanic or Latinx? ☐ Yes ☐ No ☐ Prefer not to answer
What is your race? ☐ Alaska Native ☐ American Indian ☐ Asian
☐ Black or African-American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Unknown ☐ Other
Health insurance plan name and member ID number: _____
Emergency contact (name, relationship, and phone number):
_____

REFERRING STAFF MEMBER INFORMATION

Staff member name and agency: _____
Direct phone number and email address: _____

HEALTH INFORMATION

Mental Health and Substance Use Disorder Information
Please list all mental health and/or substance use disorder diagnoses below.

1. _____ Diagnosed by: _____ Year: _____

2. _____ Diagnosed by: _____ Year: _____

3. _____ Diagnosed by: _____ Year: _____

4. _____ Diagnosed by: _____ Year: _____

5. _____ Diagnosed by: _____ Year: _____

6. _____ Diagnosed by: _____ Year: _____

Do you take medication for any of these diagnoses? ☐ Yes ☐ No

If yes, please list medications taken to treat these diagnoses:

Mental Health Providers

Do you have currently have a mental health therapist? ☐ Yes ☐ No
If yes, provider name and contact information:

_____

When was the last time you were seen by any type of mental health provider (e.g., therapist, psychiatrist, etc.)? _____

Do you have currently have a psychiatric prescriber (e.g., psychiatrist, nurse practitioner)?
☐ Yes ☐ No
If yes, provider name and contact information:

_____

Medical Information
Please describe all medical conditions below.

Do you take medication for any of these conditions? ☐ Yes ☐ No

If yes, please list medications below to treat these conditions:

Please list all current medical providers connected to your care:

Name: _____
Specialty: _____ Organization/Practice Name: _____

Name: _____
Specialty: _____ Organization/Practice Name: _____

Name: _____
Specialty: _____ Organization/Practice Name: _____

Name: _____
Specialty: _____ Organization/Practice Name: _____

ELIGIBILITY INFORMATION

Within the past 90 days, have you experienced any of the following?

An inpatient psychiatric stay? ☐ Yes ☐ No
If yes, dates of stay: _____ Name of facility: _____
Reason for admission: _____
Plan at time of discharge: _____

Two or more emergency department visits, or behavioral health emergency services program visits, for mental health or substance use reasons? ☐ Yes ☐ No
If yes please share information on at least two of the visits:

1. Date of admission: _____ Name of hospital: _____
   Reason for admission: _____
   Plan at time of discharge: _____

2. Date of admission: _____ Name of hospital: _____
   Reason for admission: _____
   Plan at time of discharge: _____

Difficulty managing your diagnoses while utilizing other community-based supports (e.g., outpatient centers, Clinical Stabilization Services (CSS) or Transitional Support Services (TSS)): ☐ **Yes** ☐ **No**

If yes, please describe, and indicate which services you have attempted to engage with in the past 90 days:

OTHER INFORMATION

Some of our programs have bunk beds. **Do you have any issues that would prevent you from accessing and sleeping in a top bunk?** ☐ Yes ☐ No

Do you currently have any pending legal issues? ☐ Yes ☐ No
If yes, where and what charges:

Do you currently receive any income? ☐ Yes ☐ No
If yes, please describe:

Please describe what you would like to get out of your stay with us and how you think we can best support you during this time:

Please attach a biopsychosocial assessment, a full medication list, and a recent TB screen to this referral and fax to: 617-506-7508 or email to: residentialtreatment@voamass.org