1304 Commonwealth Ave
Suite B Boston MA 02134
P: 617-482-5292 (TDD/Voice)
F:617-482-5232

REFERRAL FORM FOR COURT MANDATED SERVICES

****** ALL INFORMATION IS REQUIRED IN ORDER TO PROCESS REFERRAL ******

1. THE COMMUNITY CLINIC PROCESS THE REFERRALS **WITHIN 1-3 BUSSINESS DAYS** FROM DATE OF REFERRAL RECEIVED. TCC WILL COMMUNICATE WITH THE PRIMARY POINT OF CONTACT AND PERSON SERVED ONCE THE REFERRAL IS PROCESSED.
2. FOR ALL REFERRALS WITH EXCEPTION OF SELF-PAY, ***PLEASE FORWARD A PICTURE OF FRONT AND BACK OF HEALTH INSURANCE CARD***
3. **PLEASE FORWARD ALL COURT DOCUMENTS** (I.E POLICE REPORTS, RELEVANT EVALUATIONS ECT…) TO PREVENT DELAYS

Referral for Service *(select all that apply)*

- ☐ **24Q Evaluation**
- ☐ **Substance Use Evaluations**
- ☐ **Substance Use Assessment & Counseling**
- ☐ **Gambling Evaluation & Treatment**
- ☐ **Mental Health Evaluation**
- ☐ **Mental Health Services *(specify below)***
  - ☐ **Anger Management** ☐ **Outpatient Therapy**
  - ☐ **Other:** _____

Person Referred for Services

Name *(First, MI, Last)* _____ **DOB** *MM/DD/YYYY* _____ **Last 4 SSN** _____

Mailing Address *(Street or PO Box)* _____ **City, State** _____ **Zip Code** _____

Contact Number _____ **Email** _____

Gender ☐ Female ☐ Male ☐ Non-binary/conforming ☐Trans-female ☐ Trans-male

Preferred Language ☐ English ☐ Other _____ ☐ **Interpreter needed**

Other Accommodations needed: _____

Court Information

Referral Date _____ **Referring Court** _____

Arrest Date _____ **Probation End** _____ ***B.A.C.*** _____

Probation Officer

Print Name _____

Contact Number _____ **Email** _____

Primary Point of Contact for monthly reporting: ☐ **Same as above**

Print Name _____

Contact Number _____ **Email** _____

Please send copy or picture of front and back of card.
Insurance Name: _____
Policy Number _____
Group number _____

Referral form accepted via scan & email referral@docwayne.org or fax (617) 482-5232

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4. ALL REFERRALS REMAIN OPEN FOR 90 DAYS AFTER THIS TIME IT IS CLOSED AND A NEW REFERRAL IS NEEDED.

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