Lahey Health
Behavioral Services **Cape Ann Adult Behavioral Learning Center**
35 Congress St. Bld 2 Suite 351A, Salem, MA 01970 **Phone**: 978-524-7133 **FAX**: 978 524-7137
Please fax this form back and an intake clinician will call you with an intake time.

Request for Services

Date of Referral _____ **MIS #**_____

Referral Name and Agency _____**Phone #** _____

Referral Name and Agency *Email Address* _____

PERSON SERVED NAME _____**DOB** _____

Address _____ **Phone #** _____

Insurance Name/ID # _____ **Social Security #** _____

Will Person Served need a PT-1 ride set up? Yes No **Any special considerations for ride?**_____

Presenting Problem/Reason for referral (including legal issues, addictions, recent hospitalizations, symptoms, etc.)

_____

_____

Risk Factors:_____

_____

Living with: alone children spouse or partner parents family roommate/s group home foster care

Diagnosis: Axis I_____Axis II_____

Axis III_____ Axis IV _____Axis V_____

LHBS (current or past)_____

Prescribing Psychiatrist or RNCS:_____ **Phone #** _____

Agency and Address: _____ **Fax #**_____

Current Medications and dosages: (or attach list)_____
_____
_____

Psychotherapist: _____ **Location:** _____**P#**_____**F#**_____

Primary Physician (PCP) _____ **Location:** _____**P#**_____**F#**_____

Other Provider: _____ **Location:** _____**P#**_____**F#**_____

Comments/ special considerations (guardianship, etc.): _____

Date of Intake: _____Time of Intake _____Clinician _____

Please fax insurance card with referral.