The Support Network
Champions for Children's Emotional Health

REFERRAL FORM

Send by Fax: 413-538-6337 or Email: mjess@wmtcinfo.org

FAMILY INFORMATION (Please fill in as much information as possible) **DATE: ____________________**

Parent/Guardian: ____

Address: ____City: ___________________________Zip________________

Home Phone: __________________ Cell: ______________________ Email: ____

Primary Language in the household: ____

Name of Child	M/F	Age	D.O.B.	Grade	School	Town

*Please place an asterisk next to the names of the children for whom family is seeking help

Primary diagnosis or social, emotional/ behavioral challenge: (Reason for referral)

____

____

Please check

Type of Service Requested: Check all that apply

____Phone contact
____Support Group
____School/IEP
____General Information
____Resources
____Mailing List
____Court/Legal
____Other:______________________
____

Parent: Do you give permission for the Support Network to talk with this referring agency? _____YES _____NO

Referring Agency Information

How did you hear of us? ______________________________ Referring Person: ______________________________________
Agency Name: ______________________________________ Address: ____
City: ______________________ Zip: ____________ Phone: (___) __________________________ FAX: _____________________
Email: ____

Please check (all that apply) if the family is being supported through: ☐DMH ☐DDS ☐DPH ☐DCF ☐CBHI ☐CONTINUUM ☐OTHER: ___________________

Note: If a family has DDS Services for the child/children named above we cannot provide support

PLEASE BE AWARE THAT FAMILIES MAY BE PLACED ON A WAITLIST BASED ON FAMILY SUPPORT SPECIALIST AVAILABILITY

For Office Use Only

Received: ___________________ **Assigned to: ____________________**

The Support Network, a program of The Consortium 187 High Street, Holyoke MA 01040 413-536-2401 Ext 3005