UMass Memorial Health
HARRINGTON

Recovery Services
Phone: (508) 765-2207
Fax: (508) 765-2796

Mental Health Services
Phone: (508) 765-2222
Fax: (508) 764-2462

Centralized Intake Form

Patient Name:_____DOB:_____
Referred By:_____Date: _____

Reason for Referral: Be as Specific as possible re: Goals of Treatment- If a Child, referral, please indicate whether school or office based.
Check all symptoms that apply:
☐ Anxiety ☐ Depression ☐ Hyperactivity ☐ Distractibility ☐ Aggression ☐ Poor Social Skills ☐ Substance Use
☐ Suicidal Thoughts ☐ Anger ☐ Self-Harming Behavior ☐ Poor Self-Esteem ☐ Family Stress
☐ Other/ Additional info:

_____
_____
_____

SS#_____ Ethnicity: _____ Marital Status: _____ Military Service: ☐ Yes ☐ No

Complete Home Address: _____
Phone Number: _____ Alternate # _____

Email address: _____ Custody Agreement: ☐ Yes ☐ No
Copy of custody agreement signed by court will be needed at intake

Guarantor/ Caregiver/ Rep Payee/ Conservator:
Name: _____ Phone #: _____
If Employed, Please list Employer name: _____

Primary Insurance: _____ Policy # _____
2nd Insurance Name: _____ Policy # _____

Emergency Contact
Name: _____Phone: _____Relationship: _____

Service Information

Present Services:
PCP (name and address): _____
Psychiatrist (Name/ Agency/ Address/Phone #): _____
Therapist (Name/ Agency/ Address/ Phone #):_____
DCF (location and worker): _____

Below for Adults Only

Current SA services: ☐ OP ☐ MTD ☐ SUB if yes, where: _____
Sexual Offender History? ☐ Yes ☐ No
Felony Incarcerations? ☐ Yes No ☐
Dates of incarceration: Year From _____ To _____ Charge _____

Year From _____ To _____ Charge_____
_____
Parole Officer/ Court: _____
Probation Officer/ Court: _____

For PHP Only:
Pharmacy: _____ Transportation: ☐ Self ☐ PT1 needed ☐ Other: _____
Diet Preference: ☐ Dairy Free ☐ Gluten Free ☐ Vegetarian ☐ Food Allergy: _____

Appt Date _____Time _____ Location _____ Clinician _____