995 Worthington Street, Springfield, MA 01109
Telephone (413) 734-5376 FAX (413) 737-7949

Service Enhancement Team (SET) Referral Form

Participant Name: Click here to enter text. **Date of Request:** Click here to enter text.

Participant's MHA Program Involvement: Click here to enter text.

Referring staff person's name and position: Click here to enter text.

Issue, concern or problem prompting referral to SET: Click here to enter text.

Identifying Information: (Name, age, gender, racial/ethnic identification, relational status, living situation and length of time in this situation, employment or day program and length of time. Significant health or medical issues. Current MH treatment involvement.

Click here to enter text.

Presenting Problem and History of Presenting Problem (How long has this been going on and how has it changed over time?)

Click here to enter text.

Participant's perspective on the problem and stage of change.

Click here to enter text.

What's been tried already?

Click here to enter text.

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Participant's willingness to be involved in the SET meeting?

Click here to enter text.

Other providers, family, guardian, peers, etc. invited?

Click here to enter text.

Recommendations and Follow-up:

Click here to enter text.

Follow-up by:

Click here to enter text.	Date of Follow-up:	Click here to enter text.