Collective Voices Referral Form

Of note: Collective Voice's grief support providers are not mental health clinicians. CV offers grief support as an ancillary/supportive mental health service. Grief support services through CV are not a replacement for primary mental health therapy or treatment services. If in doubt about whether your client is appropriate for grief support services, please consult the MHP on the client's team.

Date of Referral:

Referring Funding Source. Please check the box that applies:

- ❑ CCS
- ❑ CLTS
- ❑ CCF
- ❑ Self-Pay
- ❑ Other _____

Client Information:

Name: Date of Birth and Age:

Race/Ethnicity (optional): Phone (best):

Preferred Pronouns: Email:

Address:

Employment (optional):

School/ Current Grade Level (optional):

Emergency contact (name, relationship, cell, email):

For minors only:

Parent/Guardian Name(s):

Phone: Email:

Parent/Guardian Address: SAME as client? If yes, you can just write "same" below.

Referral Source, Case Coordinator, or Service Facilitator Information:

Agency (Name and role):

Phone Number: Email:

Services Requested:

- ❑ Individual Skill Development (CCS only)
- ❑ Psychoeducation (CCS and CCF)
- ❑ Special Therapy (CCF only)
- ❑ Other:

Hours authorized/desired (please include the # of hours/week or month):

Availability for services (days and times that work best for the client to meet):

Please list current and prior Mental Health and Substance Use Diagnosis (es):

Safety Concerns: Please attach additional pages if needed):
History of suicide or homicidal ideation: ___ yes ___ no

Did client have a plan/means? ____yes ____no

If yes, any history of attempts ___yes ____ no

If yes, please provide additional information: month/year, circumstances, and any interventions (i.e. hospitalization, services, supports):

Actively suicidal or homicidal? ___ yes ___ no

If yes, does the client have an updated safety plan? ___ yes ___ no

Historical and/or current self-harming behaviors (i.e. hitting self, cutting, burning, hair pulling, skin picking, scratching)? ___ yes ___ no

Can you share a bit more about the coping skills they use "in the moment" or on their own to manage emotional distress?

Are they able to identify (ex. using a scale of 0-10, specific words) when they are becoming activated and/or are experiencing emotional distress? ___ yes ___ no

Currently what is their comfort level relaying where they are at emotionally to trusted individuals/current providers?

Current Treatment Provider(s): See "of note" on the top of the referral form regarding the importance of the client having an established mental health therapist before beginning grief support.

Name Agency Role on team (i.e. therapist, prescriber, etc.) Month/Year Services Started

Client Strengths:

Client Barriers/Challenges:

Reason for Referral – please be as specific as possible (attach additional pages if needed):

Service Goals (In client's words; what does the client hope to learn, gain from engaging in services with Collective Voices)?

Please provide any additional information that will allow Collective Voices to better serve the consumer. Please submit it to Jessie Kushner at collectivevoices2019@gmail.com.
Once I receive this completed form, I will reach back out to you! Thank you! 😊 Jessie Kushner