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Checklist to Refer Youth to a DMH Statewide Service (ACCU/IRTP/CIRT)

Please review the Statewide Services Flow Chart before submitting a referral.
To complete a referral for a DMH Statewide Service (ACCU/IRTP/CIRT), please use the checklist below. Documents can be securely submitted to transferscreenings@mass.gov

Check If Included	Medical Records Documentation	For DMH Use Only ~ Document Verification
☐	**Psychiatric Initial Evaluation** (including relevant psychiatric history and current diagnoses)	☐ Complete ☐ Incomplete Date Received
☐	**Physical Examination** (including relevant medical history)	☐ Complete ☐ Incomplete Date Received
☐	**Clinical Assessments** (including psychosocial, psychological, nutrition or neuropsychological)	☐ Complete ☐ Incomplete Date Received
☐	**Psychiatrist's/APRN's narrative of hospital course,** including:	☐ Complete ☐ Incomplete Date Received
	•Treatment course	
	•Patient's adherence to treatment	
	•Medication trials	
	•Diversionary efforts	
	•Rationale for locked level of care	
☐	**Nursing Progress Notes** (the last **7 days** prior to submission)	☐ Complete ☐ Incomplete Date Received
☐	**Psychiatrist's/APRN's Notes** (the last **7 days** prior to submission)	
☐	**Current Medications** (Including last **7 days** of MAR prior to submission)	☐ Complete ☐ Incomplete Date Received
☐	**Testing Information** (including labs, radiology, and consultations)	☐ Complete ☐ Incomplete ☐ N/A Date Received

Check If Included	Referral and Legal Documents	For DMH Use Only ~ Document Verification
☐	Request for Transfer Form, signed by the treating physician	☐ Complete ☐ Incomplete Date Received
☐	1 signed DMH Two-Way Authorization for Release of Medical Records **between hospital and DMH** (signed by Legally Authorized Representative)	☐ Complete ☐ Incomplete Date Received
If Applicable:		
☐	**Current Mittimus/Guardianship/Conservatorship**	☐ Complete ☐ Incomplete Date Received
☐	**Section 8B/Current Rogers Order and Treatment Plan**	☐ Complete ☐ Incomplete Date Received
☐	DMH Request for Services Application (If youth is not a current DMH client)	☐ Complete ☐ Incomplete Date Received

Patient Name:		Social Worker Assigned:	
Social Worker Assigned Phone:		Social Worker Assigned Email:	
Date Referral Packet Submitted:		Date Referral Packet Complete:	

This form is effective May 15, 2025. The form is subject to ongoing review and revision as necessary.

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