THE LEARNING CENTER FOR THE DEAF

Walden Community Services Referral Form

Youth Name:	**Date of Birth:**
MassHealth #:	**SSN:**

Service(s) Requested

☐ Intensive Care Coordination/Family Partner ☐ Therapeutic Mentoring (TM) ☐ Unsure
☐ In-Home Therapy (IHT) ☐ Family Partner (Other Hub)

Date of Referral:	
Referred By:	Agency/ Role:
Phone:	Fax or Email:

YOUTH INFORMATION

Deaf ☐ Hard of Hearing: ☐ Hearing ☐ **Youth's Primary Language:**		
Ethnic or Racial identity African American ☐ Asian ☐ Caucasian ☐ Multi-racial ☐ Other ☐		
Gender Male ☐ Female ☐ Transgender ☐ Other ☐		
Parent/Guardian 1:		
Phone:	Email:	Fax:
Address:		
Parent/Guardian 1 Primary Language:		
Parent/Guardian 2:		
Phone:	Email:	
Address:		
Parent/Guardian 2 Primary Language:		

Reason for Referral or Presenting Problem:

DSM DIAGNOSTIC CRITERIA - ICD-10 Code - Please include name & code (for IHT and TM ONLY)

Please Fax this form to our secure Fax (508) 532-6654
Walden Community Services, 63 Fountain Street, Framingham, MA 01702
Phone: (508) 875-9529 – Video Phone: (774) 406-3921 – Text: (774)423-6430