



**EXTENDED DAY TREATMENT
REFERRAL FORM**

Date Received By:
DCF Gatekeeper:
EDT Program:

REFERRAL SOURCE: (Check One)			
<input type="checkbox"/> DCF SW:	Office:	Telephone:	- -
<input type="checkbox"/> DCF Supervisor:	Office:	Telephone:	- -
<input type="checkbox"/> System of Care Coordinator:		Telephone:	- -
<input type="checkbox"/> Community Collaborative:		Telephone:	- -
<input type="checkbox"/> Other Name:	Agency:	Telephone:	- -

REQUESTED EDT PROGRAM:

REASON FOR REFERRAL:

DEMOGRAPHICS			
Child's Name:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	DOB:	
Address:		Telephone:	- -
City:	State:	Zip Code:	
SS#:	Child's DCF Link Number:		
Child's Primary Insurance:		ID#:	
Child's Secondary Insurance:		ID#:	
Primary Language: Parent/Caretaker:		Child:	
Secondary Language: Parent/Caretaker:		Child:	
Parent/Caretaker's Name:			
Address:			
Telephone: Home:	- -	Work:	- -

PARENT/CARETAKER'S RELATIONSHIP TO CHILD
<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Other:

Have the caregivers been informed about the requirements for family involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No

PERSONS LIVING IN THE HOME WITH CHILD:			
NAME	GENDER	DATE OF BIRTH	RELATIONSHIP TO CHILD

ETHNICITY (Check One):
<input type="checkbox"/> Asian American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black <input type="checkbox"/> White
<input type="checkbox"/> Native American <input type="checkbox"/> Other

CHILD'S CURRENT DCF STATUS (Check One):		
<input type="checkbox"/> Dual Commitment	<input type="checkbox"/> Committed Abuse/Neglect	<input type="checkbox"/> Committed Delinquent
<input type="checkbox"/> Families with Service Needs	<input type="checkbox"/> Voluntary	<input type="checkbox"/> No Involvement
<input type="checkbox"/> Protective Services (Investigation)	<input type="checkbox"/> Active (Protective Services Case)	

CHILD'S MENTAL HEALTH / MEDICAL ISSUES		
CURRENT DSM-IV DIAGNOSIS	DATE:	BY WHOM:
AXIS I:		
AXIS II:		
AXIS III:		
AXIS IV:		
AXIS V:	Current GAF:	Highest in past 6 months:

CURRENT AND PAST BEHAVIORAL HEALTH TREATMENT PROVIDERS / AGENCIES			
NAME OF PROVIDER / AGENCY	TYPES OF SERVICES	DATES OF SERVICES	TELEPHONE NUMBER

Child's Psychiatrist:	Telephone Number:
Child's Therapist:	Telephone Number:

DESCRIBE ANY CURRENT MEDICAL PROBLEMS:
Does the child take any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (Meds for physical and/or behavioral health reasons)
If yes, please list the medications, if known.

Child's Pediatrician:	Telephone Number:
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OTHER AGENCIES / PROGRAMS INVOLVED WITH CHILD AND SERVICES PROVIDED:

COLLATERAL CONTACTS	
Name of School:	Town:
Contact Person:	Telephone Number:
Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No	Full Scale IQ (If Known):
Probation / Parole Officer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact Person:	Telephone Number:

TRAUMA HISTORY	
HAS THE CHILD BEEN EXPOSED TO ANY OF THE FOLLOWING TRAUMATIC EXPERIENCES? (CHECK ALL THAT APPLY)	
Physical Abuse: <input type="checkbox"/>	Community Violence or Victimization: <input type="checkbox"/>
Sexual Abuse: <input type="checkbox"/>	Significant Loss (Attachment Disruptions/Multiple Placements) <input type="checkbox"/>
Domestic Violence: <input type="checkbox"/>	Unknown: <input type="checkbox"/>

PRESENTING CONCERNS

Please indicate behaviors that the child demonstrates on the chart below. If necessary, please elaborate or add additional concerns on a separate sheet.

SYMPTOMS	CURRENT	HISTORY	EXPLANATION OF CHECKED ITEMS
Self-Injurious	<input type="checkbox"/>	<input type="checkbox"/>	
Aggressive towards others	<input type="checkbox"/>	<input type="checkbox"/>	
Destroying Property	<input type="checkbox"/>	<input type="checkbox"/>	
Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>	
Homicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>	
Sexualized Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	
Lying	<input type="checkbox"/>	<input type="checkbox"/>	
Temper Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Running Away	<input type="checkbox"/>	<input type="checkbox"/>	
Truancy	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive Limitations	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>	
Bedwetting/Soiling	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE DESCRIBE CHILD'S STRENGTHS (Interpersonal, Community Interests, Other)

<p>DCF SOCIAL WORKER OR SYSTEM OF CARE COORDINATOR If available, at or prior to the intake interview please provide past treatment records, reports, and/or evaluations.</p>

Signature of Referring Source Date: _____

Signature of DCF Liaison/Gatekeeper Date: _____
(For DCF Referrals)