EXTENDED DAY TREATMENT
REFERRAL FORM

Date Received By:	
DCF Gatekeeper:	
EDT Program:	

REFERRAL SOURCE: (Check One)		
☐ DCF SW:	Office:	Telephone: - -
☐ DCF Supervisor:	Office:	Telephone: - -
☐ System of Care Coordinator:		Telephone: - -
☐ Community Collaborative:		Telephone: - -
☐ Other Name:	Agency:	Telephone: - -

REQUESTED EDT PROGRAM:

REASON FOR REFERRAL:

DEMOGRAPHICS

Child's Name:	Gender: ☐ Female ☐ 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

☐ Parent ☐ Foster Parent ☐ Guardian ☐ Relative ☐ Other:

Have the caregivers been informed about the requirements for family involvement? ☐ Yes ☐ No

PERSONS LIVING IN THE HOME WITH CHILD:

NAME	GENDER	DATE OF BIRTH	RELATIONSHIP TO CHILD

ETHNICITY (Check One)**:**

☐ Asian American ☐ Pacific Islander ☐ Hispanic/Latino ☐ Black ☐ White

☐ Native American ☐ Other

CHILD'S CURRENT DCF STATUS (Check One)**:**		
☐ Dual Commitment	☐ Committed Abuse/Neglect	☐ Committed Delinquent
☐ Families with Service Needs	☐ Voluntary	☐ No Involvement
☐ Protective Services (Investigation)	☐ 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? ☐ Yes ☐ No ☐ Unknown **(Meds for physical and/or behavioral health reasons)**	
If yes, please list the medications, if known.	
Child's Pediatrician:	Telephone Number:
OTHER AGENCIES / PROGRAMS INVOLVED WITH CHILD AND SERVICES PROVIDED:	

COLLATERAL CONTACTS	
Name of School:	Town:
Contact Person:	Telephone Number:
Special Education: ☐ Yes ☐ No	**Full Scale IQ (If Known):**
Probation / Parole Officer: ☐ Yes ☐ 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: ☐	Community Violence or Victimization: ☐
Sexual Abuse: ☐	Significant Loss (Attachment Disruptions/Multiple Placements) ☐
Domestic Violence: ☐	Unknown: ☐

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	☐	☐	
Aggressive towards others	☐	☐	
Destroying Property	☐	☐	
Psychotic Symptoms	☐	☐	
Suicidal Ideation	☐	☐	
Homicidal Ideation	☐	☐	
Sexualized Behaviors	☐	☐	
Stealing	☐	☐	
Lying	☐	☐	
Temper Tantrums	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Running Away	☐	☐	
Truancy	☐	☐	
Substance Abuse	☐	☐	
Cognitive Limitations	☐	☐	
Developmental Delays	☐	☐	
Bedwetting/Soiling	☐	☐	
Other	☐	☐	

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

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.

Signature of Referring Source **Date:**

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