



DATE OF REFERRAL: ___/___/___

REQUEST FOR SERVICE

Date of receipt: ___/___/___
Child First Staff Initials: _____

CHILD INFORMATION:

Name (First / Last): _____ **DOB:** ___/___/___ **Age:** _____

Gender: Male Female Transgender Non-Binary Other _____

Racial Origin: American Indian/Alaskan Native Asian Black/African-American
(check one) Native Hawaiian/Other Pacific Islander White Other

Hispanic Origin: Hispanic Non-Hispanic

Client Insurance Husky A Husky B Private _____ Unknown None

CAREGIVER INFORMATION – Person(s) with whom child resides:

1st Caregiver Name: _____ **Age:** _____ **Gender:** M F T NB

Relation to child: biological parent adoptive parent foster parent relative _____ other _____

2nd Caregiver Name (optional): _____ **Age:** _____ **Gender:** M F T NB

Relation to child: biological parent adoptive parent foster parent relative _____ other _____

Street address: _____ **Town/State/Zip:** _____

Phone: (check preferred #) Home : _____ Mobile : _____ Work : _____

Best times to contact: 7-9am 9-12pm 12-5pm 6-9pm **Email address:** _____

Is this the child's legal guardian? Y N unknown **If no, name of legal guardian:** _____

Legal guardian contact information: _____

Days & Hours available for services: M T W Th F // 8 am – noon noon – 4 pm 4-7 pm

Is English spoken fluently by caregiver/guardian? yes no unknown **Primary language:** _____

Do you have caregiver's permission to make referral? yes no **If yes,** written verbal both

Has family previously been served by Child First? yes no unknown **If yes, when?** _____

Does child/family have history of DCF involvement? none yes, present yes, past unknown
If yes: CPS FAR unknown **Name of FAR agency:** _____

REFERRAL SOURCE INFORMATION

Name: _____ **Relation to caregiver/guardian:** _____

Name of agency: _____ **Position:** _____

Street address: _____ **Town/State/Zip:** _____

Telephone: Office: _____ **Mobile:** _____ **Fax:** _____

Best times to contact: 7-9am 9-12pm 12-5pm 6-9pm **Email address:** _____

Type of Referral Source: Caregiver self-referral Relative

<input type="checkbox"/> Birth to Three	<input type="checkbox"/> Early Childhood Consultation Partnership (ECCP)	<input type="checkbox"/> Home visiting (Nurturing Family, PAT, EHS, NFP)
<input type="checkbox"/> Court personnel	<input type="checkbox"/> Early childhood education/childcare	<input type="checkbox"/> Hospital – Emergency Room (ER)
<input type="checkbox"/> Dept of Children and Families (DCF)	<input type="checkbox"/> Emergency Mobile Psychiatric Service (EMPS)	<input type="checkbox"/> Hospital – Obstetrics
<input type="checkbox"/> DCF – Home-based service (IFP, FBR, IICAPS, FES-Triple P, Caregiver Support Team, other _____)	<input type="checkbox"/> Faith based organization	<input type="checkbox"/> Mental health provider - adult
<input type="checkbox"/> DCF – Care Coordination	<input type="checkbox"/> Family resource & support center	<input type="checkbox"/> Mental health provider - child
<input type="checkbox"/> Dept of Developmental Services (DDS)	<input type="checkbox"/> Health Department (WIC, Healthy Start)	<input type="checkbox"/> Regional Education Service Center (RESC)
<input type="checkbox"/> Dept of Social Services (DSS)	<input type="checkbox"/> Health provider – adult	<input type="checkbox"/> School System
<input type="checkbox"/> Dept Mental Health & Addiction Serv (DMHAS)	<input type="checkbox"/> Health provider – pediatric	<input type="checkbox"/> Shelter - family
<input type="checkbox"/> Domestic violence agency or shelter	<input type="checkbox"/> Help Me Grow	<input type="checkbox"/> Substance abuse program
		<input type="checkbox"/> Other _____

REFERRAL INFORMATION

Please describe the concerns that have led to this referral: *Please also indicate if referral is urgent and why.*
If DCF referral, please indicate status and goals.

Reasons for Referral: (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Basic needs (e.g., housing, heat, food, TANF, SNAP, HUSKY) | <input type="checkbox"/> Child abuse/neglect | <input type="checkbox"/> Parent/caregiver mental health |
| <input type="checkbox"/> Child developmental/educational concerns | <input type="checkbox"/> Risk of child out-of-home placement | <input type="checkbox"/> Parent/caregiver substance abuse |
| <input type="checkbox"/> Child behavioral/emotional concerns | <input type="checkbox"/> Risk of child expulsion from school | <input type="checkbox"/> Parent support and education needs |
| <input type="checkbox"/> Child exposure to violence | <input type="checkbox"/> Risk of family eviction | <input type="checkbox"/> Service coordination needs |
| | <input type="checkbox"/> Major child/family health concerns | <input type="checkbox"/> Other (please specify): _____ |

Other Services/Agencies Currently Involved with Child/Family: (Check and circle program if appropriate)

- | | | |
|---|--|--|
| <input type="checkbox"/> Birth to Three | <input type="checkbox"/> Early Childhood Consultation Partnership (ECCP) | <input type="checkbox"/> Home visiting (Nurturing Family, PAT, EHS, NFP) |
| <input type="checkbox"/> Court personnel | <input type="checkbox"/> Early childhood education/childcare | <input type="checkbox"/> Hospital – Emergency Room (ER) |
| <input type="checkbox"/> Dept of Children and Families (DCF) | <input type="checkbox"/> Emergency Mobile Psychiatric Service (EMPS) | <input type="checkbox"/> Hospital – Obstetrics |
| <input type="checkbox"/> DCF – Home-based service (IFP, FBR, IICAPS, FES-Triple P, Caregiver Support Team, other _____) | <input type="checkbox"/> Faith based organization | <input type="checkbox"/> Mental health provider - adult |
| <input type="checkbox"/> DCF – Care Coordination | <input type="checkbox"/> Family resource & support center | <input type="checkbox"/> Mental health provider - child |
| <input type="checkbox"/> Dept of Developmental Services (DDS) | <input type="checkbox"/> Health Department (WIC, Healthy Start) | <input type="checkbox"/> Regional Education Service Center (RESC) |
| <input type="checkbox"/> Dept of Social Services (DSS) | <input type="checkbox"/> Health provider – adult | <input type="checkbox"/> Shelter – family |
| <input type="checkbox"/> Dept Mental Health & Addiction Serv (DMHAS) | <input type="checkbox"/> Health provider – pediatric | <input type="checkbox"/> School System – Special Education |
| <input type="checkbox"/> Domestic violence agency or shelter | <input type="checkbox"/> Help Me Grow | <input type="checkbox"/> Substance abuse program |
| | | <input type="checkbox"/> Other _____ |

I _____, legal guardian of _____, give permission for this referral to be sent to the Child First affiliate agency, The Child Guidance Center of Southern Connecticut, and for information to be sent to the Child First National Program Office. I understand that I will be contacted by the Child First affiliate agency directly to learn more about Child First and if it is an appropriate service for my child and my family.

Legal guardian signature: _____ Date: _____

Referrant signature: _____ Dare: _____

PLEASE ATTACH THE CHILD FIRST CONSENT FOR SERVICES OR YOUR AGENCY'S SIGNED RELEASE OF INFORMATION FORM

PLEASE RETURN TO: Child First Assistant Director Kate Murphy, LCSW at murphyka@chc1.com