Child & Family Agency of Southeastern Connecticut, Inc.

In-Home Program Referral Form

Fax: (860) 661-4262
Email: referrals.inhome@childandfamilyagency.org
https://www.childandfamilyagency.org/forms/forms-individual/forms-in-home-referral/

Program:

Multi-Dimensional Family Therapy (MDFT) ☐

Functional Family Therapy (FFT) ☐

Not Sure (someone will call you to help determine best program fit) ☐

Date of Referral	Insurance	Insurance Number

Referral Source	Telephone	Client Email	Caregiver Email

Client's Name	Current Address (street and town and zip)	D.O.B	Gender

Caregiver's Name & Relationship to Client	Current Address (street and town and zip)	Telephone	D.O.B

Is the Client of Hispanic Origin?(Select only one)	☐No, Not of Hispanic, Latino or Spanish Origin ☐Yes, Mexican, Mexican-American, Chicano ☐Yes, Puerto Rican ☐Yes, Cuban ☐Yes, South or Central America ☐Yes, of Hispanic/Latino Origin
Client's Race:(Circle/highlight all that apply)	☐American Indian or Alaska Native ☐Asian ☐Black or African-American Native Hawaiian or other Pacific Islander ☐White ☐Other

Others Living in the Home:	Relationship to Client:	DOB:

Primary Language:	In the Home:	Out of the Home:
Child:		
Caregivers:		

Yes	No	DCF Current Worker/DCF Status	Phone Number
☐	☐		

Reason for Referral :

Substance Abuse: ☐ No ☐ Yes; **Please Explain**:

SI/HI: ☐ No ☐ Yes; **Please Explain:**

Trauma History:

Individual Domain (topics might include presentation, behaviors, substance use, coping skills, cognitive abilities, etc):

Parent/Family Domain (topics might include relationships within the family, sibling conflict, parenting styles, history, crises management):

School Domain (topics might include academic, behavioral, or social concerns):

Physical Environment/System/Community Domain (topics might include important service providers involved with the family, community support available, other systems' involvement like DCF/CSSD):

Client/Family Strengths:

What do you want the in-home program to work on with this client / family?

Family's Availability (please pick at least two days and times):
☐Monday ☐Tuesday ☐Wednesday ☐ Thursday ☐ Friday
☐Morning ☐12 pm ☐1 pm ☐2 pm ☐3 pm ☐4 pm ☐5 pm ☐6 pm ☐7 pm

Code:	Current Diagnosis (DSM-5):

Current Medications:

Name	Dose	Frequency

CURRENT AND PAST BEHAVIORAL HEALTH TREATMENT PROVIDERS / AGENCIES (DCF, Probation, mental health, etc.)			
NAME OF PROVIDER / AGENCY	**TYPES OF SERVICES**	**DATES OF SERVICES**	**TELEPHONE NUMBER**