Wellmore
Behavioral Health
Wellness for a lifetime

Date of receipt: ____/____/_____
Child FIRST Staff Initials: _____
DATE OF REFERRAL:
_____/_____/_____

Referral Form

CHILD FIRST

CHILD INFORMATION:

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

Gender: ❑ M ❑ F

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

Hispanic Origin: ❑ Hispanic ❑ Non-Hispanic

CAREGIVER INFORMATION (Person with whom child resides**):**

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

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

Is this the child's legal guardian? ❑ yes ❑ no ❑ unknown

If no, name of legal guardian: _____

Street address: _____

Town/State/Zip: _____

Telephone: Home: _____ **Work:** _____ **Mobile:**_____

Best phone number & time to reach caregiver: _____

Hours of availability for services: _____

Is English spoken fluently by parent/guardian? ❑ yes ❑ no ❑ unknown **if not, 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

Parent/Primary Caregiver Insurance Information: _____

Child's Pediatrician_____

Pediatrician Address & Phone Number _____

REFERRAL SOURCE INFORMATION

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

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

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

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

If early care /school, name of school: _____ **Classroom #:** _____

Name of Teacher: _____ **Teacher Phone:** _____ **BOE ID:** _____

Type of Referral Source: ❑ Caregiver Self-referral ❑ Total Learning ❑ Pedi PCC ❑ Psychiatry

❑ Court personnel
❑ Dept. of Children and Families
❑ Dept of Social Services
❑ Faith based organization
❑ Family resource & support center
❑ Help Me Grow
❑ Physical health provider
❑ RESC
❑ School System (LEA)

❑ Dept of Mental Health & Addiction Services	❑ Home visiting	❑ Shelter
❑ Domestic violence agency	❑ Mental health provider	❑ Substance abuse program
❑ Early childhood education/childcare:	❑ MH Consultation ECC	❑ WIC
❑ Early intervention (e.g., Birth to 3)	❑ Obstetric Clinic	❑ other_____
❑ EMPS	❑ Parent aide	

REFERRAL INFORMATION

Please describe the concerns that have led to this referral: *Please also indicate if referral is urgent and why*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Services Requested: ❑ School Consultation ❑ Home-based Services

Reasons for Referral: (Check all that apply)

❒ child developmental/educational concerns	❒ risk of child out-of-home placement	❒ parent/guardian mental health
❒ child behavioral/emotional concerns	❒ risk of child expulsion from school	❒ parent/guardian substance abuse
❒ child exposure to violence	❒ risk of family eviction	❒ basic needs (e.g., TANF, SNAP, HUSKY)
❒ child abuse/neglect	❒ major child/family health concerns	❒ Other (please specify:

Other Services/Agencies currently involved with child/family:

❒Court personnel	❒ Faith based organization	❒ Pediatric PCC
❒ Dept. of Children and Families	❒ Family resource & support center	❒ Physical health provider
❒ Dept of Social Services	❒ Help Me Grow	❒ School
❒ Dept of Mental Health & Addiction Services	❒ Home visiting or parent aide	❒ Shelter
❒ Domestic violence agency	❒ Mental health provider	❒ Substance abuse program
❒ Early childhood education/childcare:	❒ MH Consultation ECC	❒ WIC
❒ Early intervention (e.g., Birth to 3)	❒ Obstetric Clinic	❒ Other_____

Child FIRST
Child and Family Interagency Resource, Support, and Training
Strong Families… Healthy Children

PLEASE RETURN FORM TO: CHILD FIRST, WELLMORE BEHAVIORAL HEALTH. 141 East Main Street 3rd fl. Waterbury, CT 06702
PHONE: (203)-575-0466 **FAX: (203) 575-1817**