

Note: System of Care Services are voluntary for the family
CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET

Child/Youth's Name:			
D.O.B.:	Age:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Community Collaborative/System of Care:			
Was EMPS # Provided: Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of Referral:	

Referral Source Name:		Phone Number:	
Referral Source Code (please check a source code below):			
<input type="checkbox"/> (1) Danbury DCF	<input type="checkbox"/> (14) National Runaway Hotline	<input type="checkbox"/> (27) Residential Facility	<input type="checkbox"/> (44) Employee Assistance Program
<input type="checkbox"/> (2) Torrington DCF	<input type="checkbox"/> (15) Crisis Intervention Hotline	<input type="checkbox"/> (28) Police	<input type="checkbox"/> (45) Juvenile Court, Probation or Parole
<input type="checkbox"/> (3) Waterbury DCF	<input type="checkbox"/> (16) Child Guidance Clinic	<input type="checkbox"/> (29) Hospital	<input type="checkbox"/> (46) Family Advocate
<input type="checkbox"/> (4) Manchester DCF	<input type="checkbox"/> (17) Court/Public Defender/Atty.	<input type="checkbox"/> (30) Friend	<input type="checkbox"/> (47) Extended Day Treatment
<input type="checkbox"/> (5) New Britain DCF	<input type="checkbox"/> (18) Youth Service Bureau	<input type="checkbox"/> (31) School	<input type="checkbox"/> (48) Emergency Psych. Treatment
<input type="checkbox"/> (6) Middletown DCF	<input type="checkbox"/> (19) Social Service Agency	<input type="checkbox"/> (32) Norwalk DCF	<input type="checkbox"/> (49) Intensive Family Preservation
<input type="checkbox"/> (7) Norwich DCF	<input type="checkbox"/> (20) Clergy	<input type="checkbox"/> (33) Hartford DCF	<input type="checkbox"/> (50) Parent Aide
<input type="checkbox"/> (8) Meriden DCF	<input type="checkbox"/> (21) Self	<input type="checkbox"/> (34) Physician	<input type="checkbox"/> (51) Partial Hospitalization
<input type="checkbox"/> (9) New Haven DCF	<input type="checkbox"/> (22) Parent	<input type="checkbox"/> (35) Willimantic DCF	<input type="checkbox"/> (52) Dept. of Social Services
<input type="checkbox"/> (10) Bridgeport DCF	<input type="checkbox"/> (23) Info-Line	<input type="checkbox"/> (37) Relative	<input type="checkbox"/> (53) Dept. of Mental Retardation
<input type="checkbox"/> (11) Stamford DCF	<input type="checkbox"/> (24) Foster Family	<input type="checkbox"/> (41) Substance Abuse Agency	<input type="checkbox"/> (54) Private Provider
<input type="checkbox"/> (12) Hotline DCF	<input type="checkbox"/> (25) Group Home	<input type="checkbox"/> (42) Local Systems of Care	<input type="checkbox"/> (62) Emergency Room
<input type="checkbox"/> (13) DCF Unspecified	<input type="checkbox"/> (26) Temporary Shelter	<input type="checkbox"/> (43) Insurance - HMO	<input type="checkbox"/> (63) Department of Corrections
			<input type="checkbox"/> (99) Other

Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Child's Ethnicity (Please check applicable box):		
<input type="checkbox"/> (5) Central American	<input type="checkbox"/> (12) Korean	<input type="checkbox"/> (20) Mexican
<input type="checkbox"/> (6) South American	<input type="checkbox"/> (13) Laotian	<input type="checkbox"/> (21) Cuban
<input type="checkbox"/> (7) Other Spanish Speaking	<input type="checkbox"/> (14) Thai	<input type="checkbox"/> (22) African American
<input type="checkbox"/> (8) West Indies/Islander	<input type="checkbox"/> (15) Vietnamese	<input type="checkbox"/> (23) Portugese
<input type="checkbox"/> (9) Cambodian	<input type="checkbox"/> (16) Asian Indian	<input type="checkbox"/> (24) Dominican
<input type="checkbox"/> (10) Chinese	<input type="checkbox"/> (18) Bi-Racial	<input type="checkbox"/> (99) Other (Please specify)
<input type="checkbox"/> (11) Japanese	<input type="checkbox"/> (19) Puerto Rican	
Child's Race (Please check applicable box):		
<input type="checkbox"/> (1) White	<input type="checkbox"/> (3) Asian American	<input type="checkbox"/> (23) Pacific Islander
<input type="checkbox"/> (2) Black	<input type="checkbox"/> (22) Native American	

Child/Youth's Residing Address:
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CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET (Continued)

Child's Current Living Arrangement (Please check applicable box):	
<input type="checkbox"/> (0) Unknown	<input type="checkbox"/> (10) Residential Treatment Facility (Other than DCF Operated)
<input type="checkbox"/> (1) With either or both parents	<input type="checkbox"/> (11) Hospital in the Community, Psychiatric Unit
<input type="checkbox"/> (2) With relative other than parent	<input type="checkbox"/> (12) Hospital in the Community, Medical Bed
<input type="checkbox"/> (3) Foster home (in the community)	<input type="checkbox"/> (13) Psychiatric Hospital
<input type="checkbox"/> (4) Foster home (out of the community)	<input type="checkbox"/> (14) DCF Residential Treatment
<input type="checkbox"/> (5) With friend or family friend	<input type="checkbox"/> (15) DCF Psychiatric Hospital (Riverview)
<input type="checkbox"/> (6) Emergency shelter for children	<input type="checkbox"/> (20) Crisis Stabilization Bed
<input type="checkbox"/> (7) Family homeless shelter	<input type="checkbox"/> (98) Homeless
<input type="checkbox"/> (8) Safe Home/Host Home	<input type="checkbox"/> (99) Other
<input type="checkbox"/> (9) Group Home (Other than DCF Operated)	

School	Grade:	Special Ed: Yes <input type="checkbox"/> No <input type="checkbox"/>	Section 504: Yes <input type="checkbox"/> No <input type="checkbox"/>
DCF Social Worker:		Phone:	
Parent(s)/Guardian(s) Name:			
Parent(s) Address:			
Phone: (Home)	(Work)	(Cell)	(Other)
Email Address:			
Is the biological parent the legal guardian? Yes <input type="checkbox"/> No <input type="checkbox"/>		If no, who is?*	

Family Type (Please check applicable box):	
<input type="checkbox"/> (5) Emancipated	<input type="checkbox"/> (12) Adoptive Family Two Caregivers
<input type="checkbox"/> (8) Biological Family Two Caregivers	<input type="checkbox"/> (13) Adoptive Family One Caregivers
<input type="checkbox"/> (9) Biological Family One Caregivers	<input type="checkbox"/> (14) Relative and/or Guardian Care Two Caregivers
<input type="checkbox"/> (10) Foster Family Two Caregivers	<input type="checkbox"/> (15) Relative and/or Guardian Care One Caregivers
<input type="checkbox"/> (11) Foster Family One Caregiver	<input type="checkbox"/> (99) None of the above

CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET (Continued)

Primary Language Parent (Please check applicable box):

(1) English (2) Spanish (3) Other European (4) Asian (5) African (98) Other (99) Unknown

Primary Language Child (Please check applicable box):

(1) English (2) Spanish (3) Other European (4) Asian (5) African (98) Other (99) Unknown

Please check all that apply:

Child lives with: Mother Father Other (Specify) _____

Other relevant family members/persons in household	Relationship	Age	School	Grade

Other Referral Concerns:

Clinical Diagnoses (if known):

Diagnosed by/Date:

Child previously referred to Systems of Care: Yes No If yes, what collaborative or region:

Service Providers – Current and Previous

Dates	Name	Agency	Number

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Please note child's functional impairment/strengths in relation to: (Please check all applicable reasons for referral below)		
<input type="checkbox"/> (1) Suicidal Ideation	<input type="checkbox"/> (22) Witness of Physical Assault	<input type="checkbox"/> (43) Sleep Disturbance/Sleep Disorder
<input type="checkbox"/> (2) Suicidal Attempts/Gestures	<input type="checkbox"/> (23) Victim of Physical Assault	<input type="checkbox"/> (44) Severe Sibling Conflict
<input type="checkbox"/> (3) Depressed	<input type="checkbox"/> (24) Victim of Other Violent Crimes	<input type="checkbox"/> (57) Police Contact
<input type="checkbox"/> (4) Self-Mutilation	<input type="checkbox"/> (25) Pregnancy of the Child	<input type="checkbox"/> (58) Property Damage
<input type="checkbox"/> (5) Other Self-Injurious Behavior	<input type="checkbox"/> (26) High Risk Behavior (Dangerous Play, Promiscuity)	<input type="checkbox"/> (59) Theft
<input type="checkbox"/> (6) Suicide by Family Member	<input type="checkbox"/> (27) Relocation of Family	<input type="checkbox"/> (60) Threat to Life of Others
<input type="checkbox"/> (7) Death or Loss of Significant Other	<input type="checkbox"/> (28) Peer Relationship Problems	<input type="checkbox"/> (61) Extreme Verbal Abuse
<input type="checkbox"/> (8) School Phobia	<input type="checkbox"/> (29) Physical Disability	<input type="checkbox"/> (62) Cruelty to Animals
<input type="checkbox"/> (9) Suspension from School	<input type="checkbox"/> (30) Homicidal Ideation	<input type="checkbox"/> (63) Social Contact Avoidance
<input type="checkbox"/> (10) Being Expelled from School	<input type="checkbox"/> (31) Homicidal Plan	<input type="checkbox"/> (64) Over Dependence on Adults
<input type="checkbox"/> (11) Running Away	<input type="checkbox"/> (32) Physical Violence/Aggression by the Child	<input type="checkbox"/> (65) Truancy
<input type="checkbox"/> (12) Being Expelled from Home	<input type="checkbox"/> (33) Oppositional Behavior	<input type="checkbox"/> (66) Academic Problems
<input type="checkbox"/> (13) Eating Disorder	<input type="checkbox"/> (34) Sexual Offending by the Client	<input type="checkbox"/> (68) Somatic Complaints
<input type="checkbox"/> (14) Alcohol Abuse	<input type="checkbox"/> (35) Sexual Abuse of the Client	<input type="checkbox"/> (71) Bladder Difficulties
<input type="checkbox"/> (15) Marijuana Abuse	<input type="checkbox"/> (36) Fire-setting	<input type="checkbox"/> (72) Non-Compliance
<input type="checkbox"/> (16) Amphetamine Abuse	<input type="checkbox"/> (37) Delinquent Activities	<input type="checkbox"/> (73) Strange Behavior
<input type="checkbox"/> (17) Other Substance Abuse	<input type="checkbox"/> (38) Symptoms of Psychosis (delusions, thought disorder, etc)	<input type="checkbox"/> (74) Hyperactive/Impulsive
<input type="checkbox"/> (18) Significant Time Living Apart from Parents	<input type="checkbox"/> (39) Severe Mental Illness not Specified Above	<input type="checkbox"/> (75) Attentional Difficulties
<input type="checkbox"/> (19) Severe Parent-Child Conflict	<input type="checkbox"/> (40) Anxiety-Related Symptoms	<input type="checkbox"/> (76) Poor Self-Esteem
<input type="checkbox"/> (20) Witness of Domestic Violence	<input type="checkbox"/> (41) Other problem not listed above	<input type="checkbox"/> (77) Sexual Acting Out
<input type="checkbox"/> (21) Witness of Homicide	<input type="checkbox"/> (42) School Refusal	<input type="checkbox"/> (93) Problematic Bowel Activity

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Area	Strengths	Reasons for Referral (Please enter codes from previous page)	Examples/Description of Behaviors
Home & Family			
School			
Community			

Signature of parent/guardian is REQUIRED for processing

"I understand that my signature gives the referring agency permission to share the above information necessary for the referral with the Care Coordinator for the local System of Care Collaborative. I understand that this information will be used to determine eligibility for the Systems of Care."

Signature of Legal Guardian: _____

Date: _____

FAVOR, Inc. (www.favor-ct.org) is a statewide family advocacy organization, run by and for parents/guardians of children with mental health needs in Connecticut. They work collaboratively with local Community Collaboratives/Systems of Care to help families who are referred for Care Coordination. The FAVOR Family Advocacy program provides trained Family Advocates who can assist families through individual advocacy, including help in learning how to effectively advocate for their child in school, juvenile justice services or other family-identified priorities. The advocates assist families in participating at meetings, provide information/help in learning how to access resources, and linkage to parent-to-parent support.

I am not interested in FAVOR services at this time []

I would like to receive additional information on FAVOR, Inc. []

I would like my referral to be forwarded to FAVOR for Family Advocacy Services []

Signature of Legal Guardian: _____

Date: _____