CJR
WELLNESS CENTER FOR CHILDREN AND FAMILIES
REFERRAL FORM

__ WELLNESS CENTER **__WELLNESS CENTER ADULT SERVICES**

REQUESTED LOCATION (OFFICE, SCHOOL, TELEHEALTH)________________________

FAX TO (860)618-2824

Client Information

Name____ DOB_____________________

Street Address____ SS#______________________

City/State____________________________ Zip________________ Sex______Gender _________

Parent/Legal Guardian Name__________________________________

Preferred Phone Daytime or Cell ______________________________ _________________________

Guardian Email Address: ____

Does client reside with Legal Guardian? ☐Yes ☐No

If No, where does client reside?____

Race_______________ Ethnicity_______________________ Grade______________________

Primary Language ☐English ☐Spanish ☐Other, Specify:____________________________________

Appointment Availability Notes

____

Insurance Information

Subscriber/Insured Name____

Subscriber/Insured SS#_______________________________________

Insurance Company Name____

Insurance Benefits Phone #____________________________________

Policy#____________________________________ Group #__________________________________

Plan #_____________________________________ ID#_____________________________________

Does policy holder give permission to verify insurance __Yes __No

Client's Primary Care Physician Name/Phone____

Referring Information

Who is making referral (if parent/guardian or self, who directed you to make referral or gave you our name) ____

Phone______________________________________

Referral Information

Services Requested ☐Individual Therapy ☐Family Therapy ☐Group Therapy ☐Psychiatric Evaluation ☐ TF-CBT ☐ MATCH

List the key concerns to be addressed____

____

Current Diagnosis (if present)____

List of current medications____

Are there any current safety concerns- suicidal thoughts, self-harm, substance abuse (if yes be sure the family aware of 211/911 as needed)

____

____

Treatment History and approx. dates (including hospitalizations)__________________________________

____

Is client involved in any other CJR Services? ☐Yes ☐No

If Yes, what program/location?____

Are any other families members involved in CJR services, if yes what location and with whom:

____

Is there DCF involvement? ☐Yes ☐No

If Yes, name of assigned worker____

Phone____

Is treatment mandated by DCF? ☐Yes ☐No

Is there Court Involvement? ☐Yes ☐No

If Yes, name of Probation/Parole Officer____

Phone____