CORNELL SCOTT HILL HEALTH CENTER CHILD & FAMILY GUIDANCE CLINIC

Mental Health Referral Form

☐ Child & Family Guidance
428 Columbus Ave
New Haven, CT 06519
O: (203) 503-3055
F: (203) 503-3066

☐ Child & Family Guidance
226 Dixwell Ave
New Haven, CT 06511
O: (203)503-3457
F: (203)503-6548

Service Requested:

☐ Substance Abuse ☐ Mental Health ☐ TF-CBT ☐ MATCH

☐ Circle of Security ☐ Medication Management ☐ Case Management Referral

Referring Person _____ Date _____

Agency/Address _____ Tel #_____

Client Name _____D.O.B. _____ Age _____

Address_____ City/Zip Code _____

Telephone # _____ EPIC MR# _____

SS# _____School _____ Grade_____

Mother _____ Father _____

Legal Guardian _____ Relationship to Child _____

Address: _____

E-Mail Address: _____

Client speaks/understands ☐ English ☐ Spanish Only ☐ Both ☐ Other _____

Guardian speaks/understands ☐ English ☐ Spanish Only ☐ Both ☐ Other _____

Ethnicity _____ Sex: ☐ Female ☐ Male

D.C.F. Involvement: ☐ Yes ☐ No Legal Mandate: ☐ Yes ☐ No

D.C.F. Link # _____ If yes, ☐ Court ☐ Probation ☐

Has the child been diagnosed with Autism: ☐ Yes ☐ No Autism Level: ☐ 1 ☐ 2 ☐ 3

Insurance Name: _____ Policy # _____

Reason for Referral: _____

_____

_____

Any prior involvement with mental health services at the CS-Hill Health Center or elsewhere?

☐ Yes ☐ No If yes, explain briefly. _____

_____

_____

Is client suicidal or homicidal? ☐ Yes ☐ No If yes, specify_____

Any hospitalizations? ☐ Yes ☐ No If yes, specify (place, date)_____

Any current medications? ☐ Yes ☐ No If yes, specify name, prescribed by_____

_____

Any drug or alcohol abuse? ☐Yes ☐ No If yes, specify_____

Form completed by: _____

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[For Office Use Only]

☐Emergency ☐ Priority ☐ Non-Emergency

Date Assigned: _____Case Assigned To: _____