

**DCYF CLIENT REFERRAL FORM**

*Please submit this form in addition to the DCYF Referral & Referral Letter*

**CLIENT INFORMATION**

**Name**:      **Date of Birth**:

**Phone**:       **Best Reached via**  Text  Voice

**Email**

**CLIENT REFERRED FOR:**

**Psychological Evaluation with a Parenting Component (15 hours)**

**Psychological Evaluation (w/out a Parent Component) (10 hours)**

*If would like me to answer parenting specific questions, it is helpful to have additional time to complete parenting assessment measures, even if a parent child observation is not requested. If that’s the case, I may request additional hours be approved prior to starting the evaluation.*

**Neuropsychological Evaluation with a Parenting Component (17 hours)**

*Neuropsychological testing takes at least 5 hours, which does not account for the additional psychological testing. Depending on the complexity of the case, I may request for additional hours to be approved.*

**Psychological Evaluation with a Parenting Component with Interpreter (15+ hours)** *Since it usually takes twice as long to administer assessment measures and complete an interview with an interpreter, I will likely request that additional hours be approved. If an interpreter is needed, please let me know so we can discuss the number of additional hours needed.*

**A referral form with the hours outlined above is included/attached** *Yes*  *No*

**Is the client actively engaged with the Department?**  Yes  No

**Is the client aware of this referral?**  Yes  No

**Date of last contact**:

**Which describes the client and referral best? My client is:**

Very Motivated, responsive, cooperative, and ready to complete the evaluation

Somewhat Motivated and/or intermittently cooperative/responsive

Unmotivated and unresponsive

Being referred because it is a required step in the Dependency process but has not been actively engaged with the Department.

Other (please describe)

**Is your client experiencing any of the following barriers in terms of their ability to engage in the evaluation?**

Homeless

No transportation

No phone

No email

No access to the internet

Active substance use/abuse

Active mental health difficulties:  PTSD  Depression  Anxiety  Psychosis

Is the client currently engaging in visits?  Yes  No

If yes, how often?

What percentage of visits have they engaged in versus missed?

Attended:      %

Missed:      %

Has the client ever been involved in a dependency previously?  Yes  No

If yes, When?

Has the client ever had their rights terminated?  Yes  No

If yes, When?

**Please list the names, ages, and DOB of the client’s children and if they are involved in the dependency:**

Name:       Age      DOB       Involved in Dependency  Yes  No

Name:       Age      DOB       Involved in Dependency  Yes  No

Name:       Age      DOB       Involved in Dependency  Yes  No

Name:       Age      DOB       Involved in Dependency  Yes  No

**Who should be contacted to schedule the parent child observation?**

Name:

Email Address:

Phone Number:

**PLEASE PROVIDE THE FOLLOWING INFORMATION**

Assigned Case/Social Worker’s Name:

Phone Number:

Email Address:

Supervisor (name/email):

Office:

**Region 3**   **Region 4**   **Region 5**  **Region 6**

Fiduciary’s Name:

Fiduciary’s Email:

Fiduciary Supervisor (name/email):

Caregiver (name/email):

**Do you have concerns about any of the following?** (Check all that apply)

Active substance use/abuse issues

Cognitive Impairment

Learning Difficulties/Disorders

Active psychosis

Active trauma/PTSD

**What services has the client been referred to** (and have they engaged or not):

Mental Health Treatment  Engaged  Not Engaged

Substance Abuse Treatment.  Engaged Not Engaged

Parenting Classes  Engaged  Not Engaged

Domestic Violence Treatment.  Engaged  Not Engaged

Home Builders  Engaged  Not Engaged

PCIT  Engaged  Not Engaged

Other (please specify):

Engaged  Not Engaged

Other (please specify):

Engaged Not Engaged

**What has the client been told in terms of what needs to happen in order to have their child(ren) returned to their care?**

**INFORMATION COVERED IN REFERRAL LETTER** (check all that apply)

Case History (i.e., date children were removed, why the children were removed, history of involvement with CPS, etc.)

Primary concerns/Problem history

Criminal History  N/A

Substance Use History  N/A

Mental Health History  N/A

History of involvement with CPS

Active substance use/abuse issues

Names/Emails of Collateral Contacts

**Specific Referral Questions**

Pending court/trial dates I should be aware of

**RECORDS INCLUDED IN REFERRAL PACKET** (check all that apply)

CPS intakes

Investigative assessments

Dependency orders/Court reports

Case notes/visits notes

Mental health records/medical records

Criminal records/police reports (if applicable)

Any previous evaluations (e.g., mental health, substance abuse, dependency)

Anything else that is important for me to review: