

**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: