

Extended Day Treatment Referral Form

Instructions

The Extended Day Treatment (EDT) Referral Form, developed by the EDT Practice Standards Committee is to be used by all professionals who wish to make a referral to any of the state's contracted programs. This includes DCF staff, System of Care Coordinators, school personnel, hospital staff, treatment providers, residential staff and others. (Parents, guardians or relatives who are making direct referrals are not expected to use this form.) The form will be readily available within the communities and may be obtained from the respective EDT providers. The form may be completed electronically and e-mailed to the provider, or the form may be completed manually and mailed or hand-delivered to the program site.

1. Date Received By

- a) For DCF-involved cases, the DCF Gatekeeper will record the date that the completed referral form was received from the social worker or supervisor.
- b) For all referrals, the EDT provider will record the date of receipt of the referral form.

2. Referral Source

Check the appropriate box to designate the referring agent.

Provide the name, office or agency, and telephone number of the referring agent.

3. Requested EDT Program

Identify the name of the EDT program.

4. Reason For Referral

Briefly explain why the child/adolescent needs an intermediate level of care.

5. Demographics

Complete each item.

6. Parent/Caretaker's Relationship To Child

Check the appropriate box. If other, please specify the nature of the relationship.

7. Have The Caregivers Been Informed About The Requirements For Family Involvement?

Answer yes or no, as applicable.

Although the referring agent may not be aware of the detailed requirements, it is important to inform families immediately that their participation in treatment planning and service delivery is expected and an integral part of the program.

8. Persons Living In The Home With Child

List each person who resides in the home and specify gender, date of birth and relationship to child.

9. Ethnicity

Check the appropriate box.

10. Child's Current DCF Status

Check the appropriate box.

11. Child's Mental Health/Medical Issues

Indicate the date of the most current diagnosis, and the treating provider. Complete Axis I through V.

12. Current/Past Behavioral Health Treatment Providers/Agencies

List each provider/agency, types of services, dates of services, and telephone numbers.

Provide the names and telephone numbers for the child's psychiatrist and therapist, as applicable.

13. Describe Any Current Medical Problems

Briefly describe any current physical health issues.

Check whether or not the child takes any type of medication for physical and/or psychiatric health issues. If yes, list all medications.

Provide the name and telephone number of the child's pediatrician.

14. Other Agencies/Programs Involved With Child And Services Provided

List any other involved agencies or programs and identify the services provided.

15. Collateral Contacts

Answer each item. Identify contacts, as applicable. Specify IQ, if known.

16. Trauma History

Check all the boxes that are applicable.

17. Presenting Concerns

Check the appropriate boxes that describe symptoms or behaviors, indicating current or past, or both, and explain the nature of these concerns, as necessary.

18. Please Describe Child's Strengths

Identify the child's assets such as talents, interests, interpersonal skills, etc.

19. Signature of Referring Source

Referring agent must sign and date the form.

20. Signature of DCF Liaison/Gatekeeper

For DCF-involved cases, the DCF Liaison/Gatekeeper must sign/date the form.

21. DCF Social Worker Or System Of Care Coordinator

If available, at or prior to intake please provide any pertinent treatment records, reports and/or evaluations.