CONNECTICUT

Department of Children & Families

UNIVERSAL REFERRAL FORM (CT SFT)
DCF-2265
11/2024 (Rev.)

☐ Release of Information Attached ☐ Case Plan Attached	Referral For:				
Date of Referral:	Referring Unit:	DCF Office			
SW Name:	Office #:	Cell #:	Fax #:	E-mail:	
SWS Name:	Office #:	Cell #:	Fax #:	E-mail:	

PARENT / GUARDIAN / CAREGIVER #1						
LAST Name:	First Name:	M	DOB:	Gender:	CASE LINK#	PID LINK #
Relationship to Child:	E-Mail:	Race:	Ethnicity:			
Primary Language:	Bilingual Staff Required?: ☐ Yes ☐ No	Home Phone:	Cell Phone:	Work Phone:		
Address: (No. and Street):		City	State	Zip		
Primary Insurance:	Insurance ID#:	Secondary Insurance (if applicable):	Insurance ID#:			

PARENT / GUARDIAN / CAREGIVER #2						
LAST Name:	First Name:	M:	DOB:	Gender:	CASE LINK#	PID LINK #
Relationship to Child:	E-Mail:	Race:	Ethnicity:			
Primary Language:	Bilingual Staff Required?: ☐ Yes ☐ No	Home Phone:	Cell Phone:	Work Phone:		
Address: (No. and Street) IF DIFFERENT FROM ABOVE:		City:	State:	Zip:		
Primary Insurance:	Insurance ID#:	Secondary Insurance (if applicable):	Insurance ID#:			

CHILD(REN) DEMOGRAPHIC					
Child 1					
LAST Name:	First Name:	M:	DOB:	Gender:	PID LINK #
Race:	Ethnicity:	Primary Language:	Bilingual Staff Required? ☐ Yes ☐ No		
Foster Parent(s)/Facility Name		Child's Current Legal Status:			
Address: (No. and Street):		City	State	Zip	
Placement Type:	E-mail:	Identified Child?: (For Youth Programs Only) ☐ Yes ☐ No	Current Grade:	School Name:	

Child 2					
LAST Name:	First Name:	M:	DOB:	Gender:	PID LINK #
Race:	Ethnicity:	Primary Language:			Bilingual Staff Required? ☐ Yes ☐ No
Foster Parent(s)/Facility Name		Child's Current Legal Status:			
Address: (No. and Street):		City	State		Zip
Placement Type:	E-mail:	Identified Child?: (For Youth Programs Only) ☐ Yes ☐ No	Current Grade:	School Name:	
Child 3					
LAST Name:	First Name:	M:	DOB:	Gender:	PID LINK #
Race:	Ethnicity:	Primary Language:			Bilingual Staff Required? ☐ Yes ☐ No
Foster Parent(s)/Facility Name		Child's Current Legal Status:			
Address: (No. and Street):		City	State		Zip
Placement Type:	E-mail:	Identified Child?: (For Youth Programs Only) ☐ Yes ☐ No	Current Grade:	School Name:	
Child 4					
LAST Name:	First Name:	M:	DOB:	Gender:	PID LINK #
Race:	Ethnicity:	Primary Language:			Bilingual Staff Required? ☐ Yes ☐ No
Foster Parent(s)/Facility Name		Child's Current Legal Status:			
Address: (No. and Street):		City	State		Zip
Placement Type:	E-mail:	Identified Child?: (For Youth Programs Only) ☐ Yes ☐ No	Current Grade:	School Name:	
Child 5					
LAST Name:	First Name:	M:	DOB:	Gender:	PID LINK #
Race:	Ethnicity:	Primary Language:			Bilingual Staff Required? ☐ Yes ☐ No
Foster Parent(s)/Facility Name		Child's Current Legal Status:			
Address: (No. and Street):		City	State		Zip
Placement Type:	E-mail:	Identified Child?: (For Youth Programs Only) ☐ Yes ☐ No	Current Grade:	School Name:	

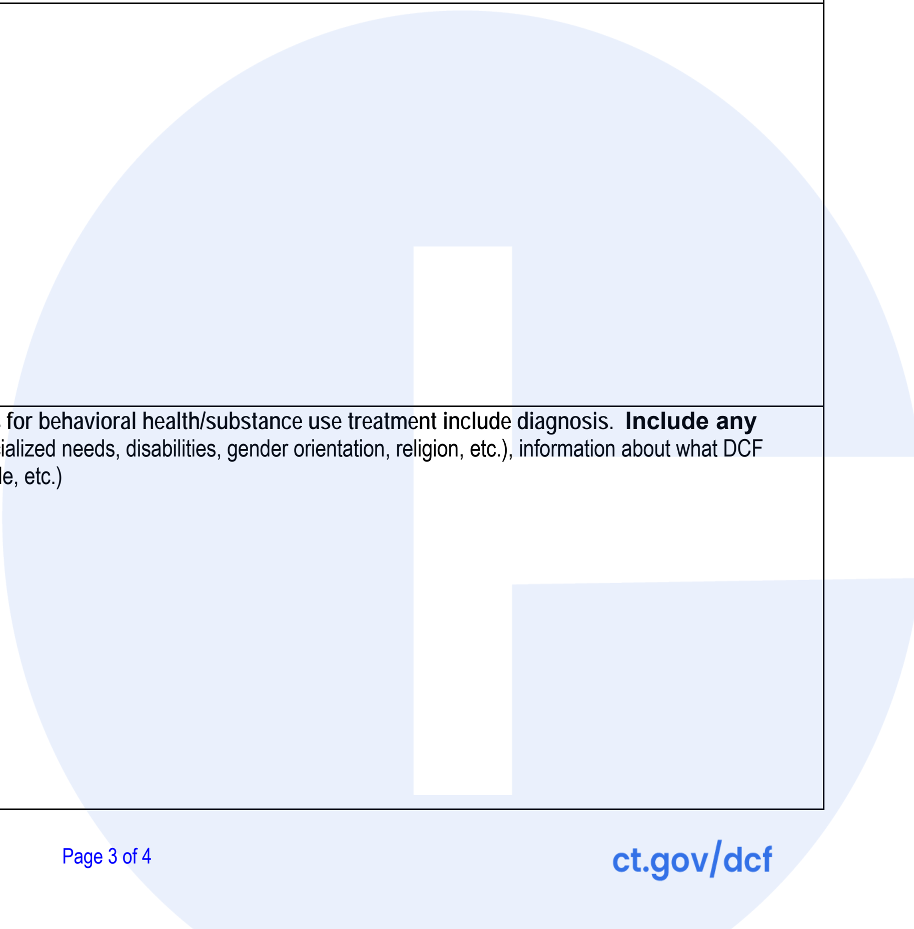
☐ If additional children or parents need to be added to this referral, please fill out a new URF with just the Demographic Information

Do Any of the Children have Medical needs? ☐ Yes ☐ No **If YES**, please indicate medically complex classification: ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Do Any of the Children have Behavioral Health needs? ☐ Yes ☐ No	
If yes, indicate which child(ren):	Briefly explain their Specialized Needs (Please include diagnosis, medications, equipment, mental health needs):

SERVICE INFORMATION

Reason for Referral (Please briefly state the reasons for continued involvement and removal, if applicable. Please include, the parental/caregiver needs, what does the person being referred need from the program?):

Family Strengths:



Other Important Information: (If you are referring parents/guardians for behavioral health/substance use treatment include diagnosis. **Include any RRG recommendations,** cultural considerations (such as specialized needs, disabilities, gender orientation, religion, etc.), information about what DCF wants program to work on, special considerations for family's schedule, etc.)

RISK FACTORS	Present	Historic	Briefly Describe: (Who in Family is Impacted and Circumstances)
☐ Emotional Abuse	☐	☐	
☐ Emotional Neglect	☐	☐	
☐ Educational Neglect	☐	☐	
☐ Intimate Partner Violence	☐	☐	
☐ Medical Neglect	☐	☐	
☐ Moral Neglect	☐	☐	
☐ Physical Abuse	☐	☐	
☐ Physical Neglect	☐	☐	
☐ Sexual Abuse (Including Sexual Exploitation/Trafficking)	☐	☐	
☐ Substance Use	☐	☐	
☐ Trauma	☐	☐	
☐ Home Environment (Pets, Weapons, Neighborhood, Conditions of the Home, etc.)	☐	☐	

SERVICES CURRENTLY BEING RECEIVED

Specify, Which Family Member:	List The Current Service(s) Being Received:	Provider Name:	Phone #:

Has the person/family received this referred service before? If yes, what impact did it have and what has changed to suggest they should receive it again?

DISCLAIMER: Please note that the intent of this Universal Referral Form is to solely determine program eligibility for the children, youth and family being referred. It is not meant to replace any communication with providers as part of the determination or program intake processes.