

Implement

Teach

Nurture

**Outpatient Program**

**Referral Form**

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| **Referral Source Information:**

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| --- | --- |
| Name: | Relationship to Child: |
| Telephone: | Date of Referral: |

**Demographics:**

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| --- |
| Child’s Name: DOB: Sex: Gender: |
| Address: City: State: Zip Code: |
| Race: | Ethnicity: |
| Guardian’s Name: | Relationship to Child: |
| Telephone: | Alternate Telephone: |
| Primary Language: | Secondary Language: |
| Child’s Primary Insurance: | Child’s Secondary Insurance: |
| DCF Involved: [ ] Yes [ ] No | DCF Worker: |
| Mental Health Diagnoses: |
| Current Therapist: | Current Prescriber: |
| Medications: |

**Reason for Referral:**Presenting Behaviors:[ ] Suicidal Ideation [ ] Physical Aggression [ ] Bedwetting/Soiling [ ] Rigid Behaviors[ ] Homicidal Ideation [ ] Verbal Aggression [ ] Stealing [ ] Sensory Issues [ ] Self-Injurious Behavior [ ] Property Destruction [ ] Lying [ ] Difficulty complying with Directives [ ] Depression [ ] Low Frustration Tolerance [ ] Truancy [ ] Difficulty Sustaining Attention [ ] Anxiety [ ] Trauma History [ ] Psychosis [ ] Difficulty maintaining Self-Control [ ] Mood Dysregulation [ ] Sexualized Behaviors [ ] Cognitive Limitations [ ] Running Away  Trauma History:[ ] Physical Abuse [ ] Sexual Abuse [ ] Domestic Violence [ ] Serious Accident/Injury [ ] Natural Disaster[ ] Verbal Abuse [ ] Neglect [ ] Family/Community Violence [ ] Disrupted Attachments [ ]  Please describe the reason for the referral in the box below:Child’s Strengths:**Past Treatment:**Please describe the child’s mental health treatment history, if applicable: |

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