****

Phone: 774-455-4127

Fax: 508-721-7038

Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LINK-KID REFERRAL FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | | | Date of Birth: | | | Age: | |
| Gender: M  F  T | | Primary Language: | | | | | Legal Custody Status: | | | | |
| Race/Ethnicity: | | LGBTQ Yes No | | | | |  | | | | |
| Address: | | | | | | | | | | | |
| City: | | | State: | | Zip: | | | | | | |
| **Referral Source Name:** | | | | | | | **Referral Source Phone:** | | | | |
| **Referral Source Relationship to youth:** | | | | | | | **Referral Source Email Address:** | | | | |
| **Mother/Guardian Name**: | | | | | | | **Father/Guardian Name**: | | | | |
| Address:  Same  Other: | | | | | | | Address:  Same  Other: | | | | |
| Telephone:  Same Other: | | | | | | | Telephone:  Same Other: | | | | |
| Primary Language: | | | | | | | Primary Language: | | | | |
| **DCF Involvement:**   Yes  No  Custody | | | | | | | **Foster Parent Name**: | | | | |
| **Social Worker Name:** | | | | | | | Address:  Same  Other: | | | | |
| E-mail Address: | | | | | | | Telephone:  Same Other | | | | |
| Telephone:  Same Other: | | | | | | | Primary Language: | | | | |
| Email Address of Caregiver: | | | | | | | | | | | |
| **Name of School:** Grade: IEP/504  Yes  No | | | | | | | | | | | | |
| **Developmental Delay/Intellectual Disability:** | | | | | | | | | | | | |
| Primary Care Physician: | | | | | | | | Telephone: | | | | |
| Other Providers Involved: | | | | | | | | Telephone: | | | | |
| Current Living Situation: | Home | | | Relative | | Foster Care | | Medical Hospital | Jail/Lock Up | | Detention | |
|  | Friends | | | Homeless | | Group Care | | Psych Hospital | Shelter/ Assessment | | Unknown | |
| Is the family involved with the military?  No  Yes If yes, please describe: | | | | | | | | | | | | |
| Is the family involved with the court system?  No  Yes If yes, please describe: | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **Primary** **Insurance Company:** | **Policy #:** |
| **Name & DOB of Insurance Carrier:** | |
| **Secondary** **Insurance Company:** | **Policy #:** |
| EBT Referred For: | Clinic Based  In-Home Therapy |
| Appointment Preference: (as availability allows) | Circle one: Morning Afternoon Evening |
| Does family have access to transportation for treatment?  Yes  No | |
| Other possible barriers to treatment: | |

**History of Trauma and Behaviors Related to the Trauma:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Trauma Screen: History (Check all that apply)**

❑Sexual Abuse ❑Emotional/Psychological Abuse ❑Domestic Violence ❑Community Violence

❑Physical Abuse ❑Severe Accident or Illness ❑ Parental Substance Abuse ❑Traumatic Grief

❑Neglect ❑War/Terrorism/Immigration ❑Natural Disaster ❑Parent Mental Illness

❑Frequent Moves ❑Parent history of trauma ❑Kidnapping ❑School Violence/Bullying

❑Homelessness ❑Parent Incarcerated ❑Parent Deployed

❑ Systems-Induced Trauma (ie. Removal/multiple placements ❑Victim of Commercial Sexual Exploitation (CSEC)

❑Separation from parent due to death, divorce, abandonment or other reason.

❑Other (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Reactions/Behaviors/Functioning Related to the Trauma (Check all that apply)**

❑Oppositional Behaviors ❑Depression ❑Self-Harm ❑Dissociation ❑Impulsivity

❑Attention/concentration ❑Conduct Problems ❑Sleep Difficulties ❑Anger Problems ❑Regression

❑Suicidal Ideations ❑Homicidal Ideations ❑Audio Hallucinations ❑Visual Hallucinations ❑Anxiety

❑Sexualized Behaviors ❑Animal Cruelty ❑Attachment/relationship

❑Somatization/Physical ❑Problems with Difficulties

Complaints Emotional Regulation ❑ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Posttraumatic Stress Reactions Related to the Trauma (Check all that apply)**

❑ Re-experiencing (nightmares, flashbacks or intrusive thoughts)

❑ Avoidance (not want to talk about the trauma, avoiding trauma reminders)

❑ Numbing (lack of emotion, social withdrawal)

❑ Hyperarousal (exaggerated startle response(s), hyper-vigilance, being “on edge”)

**\*\* Please note, we are not able to process incomplete referrals\*\***