Connecticut BHP
Supporting Health and Recovery

PRTF Referral Form

SERVING

Boys & Girls Village	The Children's Center of Hamden	Albert J. Solnit South Campus PRTF	Albert J. Solnit North Campus PRTF	The Village for Families & Children
528 Wheelers Farms Rd Milford, CT 06461 T: 203-877-0300 F: 203-876-0076 *Ages 5-13*	1400 Whitney Avenue Hamden, CT 06517 T: 203-248-2116 F: 203-248-2572 *Boys ages 7-13*	915 River Road Middletown, CT 06457 T: 860-704-4015 F: 860-704-4260 *Girls Ages: 13-17*	36 Gardner Street East Windsor, CT 06088 T: 860-292-4000 F: 860-292-4066 *Boys Ages: 13-17*	1680 Albany Avenue Hartford CT 06105 T: 860-297-0585 F: 860-523-0346 *Ages 6-12*

PLEASE FAX TO CT BHP: 855-584-2172 – ATTN: CLINICAL DEPARTMENT

Date of Referral ____________________

Referring Person ____________________ **Referring Facility** ____________________

Phone #______________________________ Fax #__________________________

Date of Admission to Hospital: ________________

Demographic Information (***PLEASE PRINT***)

Child's name:____ ☐ Male ☐ Female

Date of birth: ________________Age:____________ Ethnicity: ___________________

Current Placement:________________________Admission Date: ___________________

SSN:_____________________________Primary Language: _______________________

Medicaid ID # ____

Address: ____

City/State/Zip code: ____

Home phone: ____

Emergency Contact (Other than Primary Caregiver): _________________________________

Emergency Contact Phone: ____

	PARENT-1	PARENT-2
Name	______________________	______________________
Relationship to Child	______________________	______________________
Ethnicity	______________________	______________________
Languages	______________________	______________________
Address	______________________	______________________
Home phone	______________________	______________________
Work phone	______________________	______________________

LEGAL GUARDIAN (If other than listed above) Name ______________________

Relationship to Child______________ Home #__________Work # __________

DCF Involvement (if any):

Link Number: ______________________ Phone: __________

DCF Supervisor: ______________________ Phone: __________

DCF Program Supervisor: ______________________ Phone: __________

DCF Social Worker/Area office: ______________________ Fax: __________

Client DCF Status: ☐ OTC ☐ Committed ☐ Voluntary ☐ FWSN ☐ Investigation ☐ Protective

Juvenile Court involvement (if any):

Probation officer: ______________________ Phone: __________

Arrest History and Offence (when and why) ______________________

____

____

Living Situation (Name/Age/Relationship to member): ______________________

____

____

Family History, family psychiatric and substance abuse history, domestic violence, current family stressors that may be affecting patient: N/A______

____

____

Family's role in treatment: ____________________

Family's Strengths: ____________________

Child's Strengths: ____________________

Religious / Cultural Background: ____________________

Restrictions / Special Needs based on religious / cultural background (if any):

____

____

____

Insurance information:

Name of Primary Insurance Carrier: ____________________

Case Manager Name and Phone #: ____________________

Insurance:____________________ Plan Code: ____________________

Subscriber:____________________DOB: ____________________

Subscriber's employer:____________________

Relationship to Insured:____________________

Insurance verified: ☐ Yes ☐ No Sub-acute pre-certified with (name): ____________________

Name of Secondary insurance:____________________

Who will be funding the placement? ____________________

Has Funding been approved? ____________________

What is the main clinical need or focal problem that leads you to request admission to a PRTF?

____

____

____

____

____

____

____

What are the contributing factors to the main clinical need/focal problem? Please consider factors from multiple life domains including the individual, family, peer, school, and community:

____
____
____
____
____
____
____
____

What are the goals for the PRTF stay and the recommended interventions corresponding to the contributing factors stated above?

____
____
____
____
____

Current Diagnosis:

Behavioral Diagnoses ***(Primary is required)***

*Diagnosis Code: ______________ *Description______________________________________

*Diagnostic Category: ____

Diagnosis Code: ______________ Description______________________________________

Diagnostic Category: ____

Primary Medical Diagnoses ***(Primary is required or indicate "None" or "Unknown")***

*Diagnosis Code: ______________ *Description______________________________________

*Diagnostic Category: ____

Diagnosis Code: ______________ Description______________________________________

Diagnostic Category: ____

***Social Elements Impacting Diagnoses (Required - Check all that apply)**

☐ None ☐ Educational problems ☐ Financial problems ☐ Housing problems (Not Homelessness)

☐ Occupational problems ☐ Problems with access to health care services ☐ Homelessness

☐ Problems related to interaction with legal system / crime ☐ Problems with primary support group

☐ Problems related to social environment ☐ Unknown

☐ Other psychosocial and environmental problems ______________________________

Functional Assessment (*Optional)*

☐CDC- HRQOL ☐CGAS ☐FAST ☐GAF ☐OMFAQ ☐SF12 ☐SF36 ☐WHO DAS

☐OTHER ________________________ ASSESSMENT SCORE __________

Current Medications and Dosages: Note if medication is psychotropic or medical

Name of Drug	Dose	Schedule	Prescribing MD	Target Symptoms/Behaviors

Past Medication Trials: Note if medication is psychotropic or medical

Name of Drug	Dose	Schedule	Prescribing MD	Target Symptoms/Behaviors

Were any medications discontinued due to adverse reactions? If so, which?

____

____

____

Primary Care Physician: ______________________ Phone: ____________

Allergies: ____

____

____

Medical Issues- Significant medical history, hospitalizations?

____

____

____

Recent Testing/EKG/EEG/Cat scan? If yes, when? Any abnormalities? ____________

____

____

Identify any potential risk factors that may interact with medications: ____________

____

____

Any medical conditions that might impact during use of restraint:

____

____

Check all that apply:

☐ Birth complications ☐ Head Trauma ☐ GI Disease ☐ Siezures ☐ Asthma
☐ Cardiac ☐ Thyroid disease ☐ Diabetes ☐ HIV / AIDS

Date of Last Restraint:__________________ Reason:________________________________

Date of Last Seclusion__________________ Reason:________________________________

Date of Last PRN:_____________________ Reason:________________________________

Has the child experienced any of the following? (Please circle one response)

Aggressive behavior	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Anxiety / panic attacks	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Attention deficit disorder	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Depression	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Dissociative Features	☐ **current** ☐ **past** ☐ **unknown** ☐ **NA**
Eating Patterns/Concerns	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Fire setting	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Hallucinations-Auditory	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Hallucinations-Visual	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
History of cruelty to animals	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Homicidal threats	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Impulsive behavior	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Juvenile Court Involvement	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Oppositional behavior	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Run Away	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Self Injurious Behaviors	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Sexualized behavior	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
School problems	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Sleep problems	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Suicidal attempts	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**
Suicidal ideation	☐ **current** ☐ **past** ☐ **unknown** ☐ **N/A**

Trauma history/abuse (current/past/unknown/NA) - If yes, please explain when and by whom:

____

____

Has child ever received any of the following services? (If so, please identify where/when)

Psychiatric hospitalization:________________________________ ☐ **yes** ☐ **no** ☐ **unknown**

____

____

Substance abuse treatment ________________________________ ☐ **yes** ☐ **no** ☐ **unknown**

IICAPS/FST (in home services)_____________________________ ☐ **yes** ☐ **no** ☐ **unknown**

Outpatient treatment____________________________________ ☐ **yes** ☐ **no** ☐ **unknown**

Partial hospital program_________________________________ ☐ **yes** ☐ **no** ☐ **unknown**

Residential treatment center______________________________ ☐ **yes** ☐ **no** ☐ **unknown**

Psycho-sexual evaluation_________________________________ ☐ **yes** ☐ **no** ☐ **unknown**

Psychological testing ____________________________________ ☐ **yes** ☐ **no** ☐ **unknown**

Other ____ ☐ **yes** ☐ **no** ☐ **unknown**

School Performance

Child's Current Grade Level: ____________________________

Current School/Town: ________________________________

Special Education Classification? ☐Yes ☐ No IQ Testing Date: ____________________

IQ Scores: ____

Last PPT: __________________

Academic, Behavioral & Social Functioning in School. Note any suspensions:

____

____

Intended plan following Sub-acute treatment:

____

____

What is the long term disposition plan for this child? Reunification (if so, with whom)

____

Therapeutic Foster Care (if so, what is the status of the DCF469?)________________________

Residential Treatment (if so, what is the status of the CANS packet?) ____________________

Group Home (if so, what is the status of the CANS packet?)__________________________

What is the child's future vision for the long term disposition plan?

- ☐ Home
- ☐ Residential Treatment
- ☐ Therapeutic Foster Care
- ☐ Group Home

Current Service Providers (Name, Agency, Phone, Service Provided & Dates of Participation):

Does the child require a single room? If yes, state reason:

Previous experience with roommates:

Signature/Title of Referring Person ____
Date _____________

* Facilities may require additional documentations/information prior to approval/decision.