Connecticut Department of Children and Families

# FUNCTIONAL FAMILY THERAPY (FFT) REFERRAL FORM

DCF-109
3/17 (Rev.)

| REFERRAL SOURCE: | | DATE RECEIVED: |
|---|---|---|
| Name: | Agency: | Phone: |

**Demographics**

| Child's Last Name: | Child's First Name: | Middle: | Gender: |
|---|---|---|---|
| Child's Race: | Child's Ethnicity: | Child's DOB: | Phone: |

| Child's Current DCF Status: | |
|---|---|
| Child's Primary Insurance: | ID#: |
| Child's Secondary Insurance: | ID#: |
| **Please be advised that HUSKY is the only insurance that pays in full for FFT. Co-pays will be required for privately insured families; however, NO family will be refused services due to financial reasons. Include a signed release and any assessments that might be relevant to treatment, when submitting this form.** | Annual household Income: $ |
| Name of Parent/Caretaker: | |

| Address: | City/Town: | State: | Zip: |
|---|---|---|---|

| Parent/Caregiver's Race: | Parent/Caretaker's Ethnicity: |
|---|---|

| Primary Phone: | Work Phone: | Cell Phone: |
|---|---|---|
| Primary Language of the Parent/Caregiver: | | Child: |
| Secondary Language of the Parent/Caregiver: | | Child: |

Parent/Caregiver's Relationship to Child: ☐ Parent ☐ Foster Parent ☐ Guardian ☐ Relative ☐ Other:

Have the caregivers been informed concerning family involvement (no individual sessions, meeting at least weekly for at least nine weeks)? ☐ Yes ☐ No

**Persons Living in the home with the Child**

| Name | Gender | DOB | Relationship to Child |
|---|---|---|---|
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**Child's Mental Health / Medical Issues:**

| Current DSM-IV Diagnosis | Date: | By Whom: |
|---|---|---|
| AXIS I: | | |
| AXIS II | | |
| AXIS III: | | |
| AXIS IV: | | |
| AXIS V: Current GAF: | Highest in past 6 months: | |

**Current And Past Behavioral Health Treatment Providers / Agencies (DCF, Probation, Mental Health, Etc.)**

| Name of Provider / Agency: | Types of Services: | Dates of Services: | Phone: |
|---|---|---|---|
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| Medical Personnel Contact Information | |
|---|---|
| Child's Psychiatrist: | Phone: |
| Child's Therapist | Phone: |
| Child's Pediatrician: | Phone: |
| Does the child take any medications (for physical and/or behavioral health reasons?): ☐ Yes ☐ No ☐ Unknown | |
| If yes, please list the medications: | |
| Other Agencies / Programs Involved with child: | List Services provided: |
| | |
| | |
| | |
| List Any Current Referrals To Other Programs: | |
| **FAMILY AVAILABILITY:** Please list the times/days of the week the family could be available for sessions | |
| ☐ Afternoons (before 5:00 p.m.) | ☐ Evenings (after 5:00 p.m.) |

| School Information | |
|---|---|
| Name of School: | Town: |
| Contact Person: | Phone: |
| Special Education: ☐ Yes ☐ No | Full Scale IQ (if known) |
| Reason for Referral: | |

| Trauma History |
|---|
| Have any family members been exposed to any of the following traumatic experiences? (check all that apply and indicate which family member it pertains to): |
| ☐ Attachment Disruptions / Multiple Placements: |
| ☐ Domestic Violence: |
| ☐ Physical Abuse: |
| ☐ Sexual Abuse: |
| ☐ Significant Loss: |
| ☐ Community Violence or Victimization: |
| ☐ Other (please Specify): |
| ☐ Unknown: |
| Please Describe Family's Strengths (Interpersonal, Community Interested, other): |