Wheeler | Innovative Care. Positive Change.

Intensive In-Home Behavioral Health Services

(Serving Anthem BCBS of CT Children, Adolescents and Young Adults)

Wheeler's IIBHS 24/7 Referral Line: 1-475-222-6015
Fax: 860-793-3371
Referral Email: IIBHS@wheelerclinic.org

CLIENT INFORMATION:

Name: _____ DOB: _____

SS#_____ Race: _____

Gender: _____ Primary Language spoken in home: _____

Anthem Plan ID #: _____

Provider Services phone number (back of member card):_____

REFERRAL INFORMATION:

Referred by:

Name: _____ **Date of referral:** _____

Agency/Address: _____

Phone #: _____

Legal Status:

Court: _____Probation Officer: _____

Current/recent charges: _____

Past charges: _____

Court Orders: _____

Date of Case Review Team Meeting (CRT) **or other team meeting**_____

DCF Involved: Yes _____ No _____ Status:_____

If Yes:

Social Worker Name: _____Phone: _____

Social Work Supervisor Name:_____Phone:_____

Area Office/Address: _____

Any known/suspected safety concerns in the home? (Explain):_____

_____

REASON FOR REFERRAL:

_____

_____

_____

_____

_____

Current Substance use (describe):_____

IIBHS REFERRAL FORM

BACKGROUND INFORMATION:
Does child live with parent(s)? Yes_____ No_____

If no, adult responsible for the child's care:

Name: _____Relationship: _____

Address: _____Phone: _____

PARENTS: **Legal Guardian**

Mother's name: _____ Yes_____ No_____

Address: _____Phone: _____

Legal Guardian

Father's name: _____ Yes_____No_____

Address: _____Phone: _____

OTHERS LIVING IN THE HOME:

Name	Age	Relationship to Client

FAMILY AVAILABILITY (PLEASE CHECK OFF ALL DAYS AND TIMES THAT APPLY)

__ Mondays ___ Tuesdays ____ Wednesdays ___ Thursdays ___Fridays

__ Mornings (9am – 12pm) ___ Afternoons (12pm – 4pm) ___Evenings (4pm – 8pm)

SCHOOL:
Current School: _____Grade: _____

YOUTH'S CURRENT/PAST TREATMENT HISTORY: (if applicable)

Institute/Agency	Dates of Service	Type of Service (individual therapy, inpatient, outpatient) (home based therapy)	Discharge Status (successful/ unsuccessful)	Tel. #	Name of contact

DIAGNOSIS:

_____

_____

_____

CURRENT MEDICATION:

Name	Dose/Frequency	Prescribing Physician