Wheeler | Innovative Care. Positive Change.

CONNECTICUT CARE COORDINATION REFERRAL FORM

Fax this document attention to
Care Coordination Program Supervisor
@ 860-793-3520 or email to
TNapiello@Wheelerclinic.org

Youth Name:
Date of Birth: Age:
Gender: ☐ Male ☐ Female
Residing Address:

Parent/Guardian Name(s):
Relationship to Youth:
# of other children in home: # of other adults in home:
Address (if different):

Phone: (home) (work)
(cell) (other)
Email:

Hispanic Origin: ☐ Yes ☐ No

Race (check all that apply): ☐ Asian American ☐ Black ☐ White
☐ Other ☐ Native American ☐ Pacific Islander

Preferred Language – Parent/Guardian: Youth:

Youth & Family Strengths:

What does the youth and family consider to be their main challenges (in home, school, and/or community):

Provider Concerns (Behaviors, Recent Trauma, Relevant Family Medical Info):

What are the safety concerns for the youth and family:

Current Supports (school, friends, neighbors, family, providers, community):

NAME:	ROLE/Relationship to:	PHONE:

Referral Source Name: Phone:
Relationship/Agency: Date of Referral:
Email:
Previous family involvement in Care Coordination or Family Advocacy:
☐ No ☐ Yes (if yes when/where?)

Current School:
Grade: Special Education: ☐ Yes ☐ No ☐ 504

Current DCF Involvement (for anyone in household): ☐ No ☐ Yes
Worker: Phone:

Current JJ/Probation Involvement: ☐ No ☐ Yes
Worker: Phone:

Current Clinical Diagnoses (if known – Most Recent DSM preferred):

Recent or Pending Referrals for family (please list w/ contact info):

"I understand that my signature gives the referring agency/person permission to share the above information with the Care Coordination Program and that this information will be used to determine eligibility for that program."

Parent/Guardian Signature: ____

Date: _________________

Parent/guardian approval is required for submission/acceptance of referral.

If unable to obtain signature or submitting referral electronically please be sure to keep all protected health information (PHI) secure according to HIPPA and HITECH regulations:

☐ As the referring person/agent I have reviewed this referral with the parent/guardian and I have their permission to submit this referral for the Care Coordination program.