CONNECTICUT JUNIOR REPUBLIC
WELLNESS CENTER FOR CHILDREN AND FAMILIES/WELLNESS CENTER
ADULT SERVICES
REFERRAL FORM

__WC **__WCAS**

Client Information

Name_____ DOB_____

Street Address_____ SS#_____

City/State_____ Zip_____ Gender_____

Parent/Legal Guardian Name_____

Preferred Phone Daytime or Cell _____ _____

Does client reside with Legal Guardian? ☐Yes ☐No

If No, where does client reside?_____

Race_____ Ethnicity_____ Grade_____

Primary Language ☐English ☐Spanish ☐Other, Specify:_____

Do you prefer in person, telehealth or either____ _____

If in person, which office do you prefer_____

Insurance Information

Subscriber/Insured Name_____

Subscriber/Insured SS#_____

Insurance Company Name_____

Insurance Benefits Phone #_____

Policy#_____ Group #_____

Plan #_____ ID#_____

Does policy holder give permission to verify insurance __Yes __No

Client's Primary Care Physician Name/Phone_____

Referring Provider Information (If Not Parent or Guardian)

Referral Name _____ Agency _____

Office Phone _____ Office Fax _____

Referral Information

Services Requested ☐Individual Therapy ☐Family Therapy ☐Group Therapy
☐Psychiatric Evaluation ☐ TF-CBT ☐ MATCH

List the key concerns to be addressed _____

_____

Current Diagnosis (if present) _____

List of current medications _____

Are there any current safety concerns- suicidal thoughts, self-harm, substance abuse (if yes be sure the family aware of 211/911 as needed)

_____

Treatment History _____

Is client involved in any other CJR Services? ☐Yes ☐No

If Yes, what program/location? _____

Is there DCF involvement? ☐Yes ☐No

If Yes, name of assigned worker _____

Phone _____

Is treatment mandated by DCF? ☐Yes ☐No

Is there Court Involvement? ☐Yes ☐No

If Yes, name of Probation Officer _____ Phone _____

Is treatment court ordered? ☐Yes ☐No

Charges _____

FAX TO (860)618-2824

For Completion By Clinic Director of CJR Wellness Center for Children and Families

Date Received_____ Therapist Assigned/Location_____

Date Assigned_____ Scheduled Intake Assessment Date_____

Reason client not scheduled_____

- ☐ Referral information has been reviewed, and our available services do not best meet the needs of the client. Comments and date that referring party was notified that referral was not accepted.

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