CDH USE ONLY
Date Received: _____
Referral Source Contacted: _____
Parents Contacted: _____
Notes:
_____
_____

Intake: _____ Admit: _____
Psych Eval: _____
Group Assignment: _____
Transportation: _____

Yale NewHaven Health
Yale New Haven Children's Hospital

Children's Day Hospital IOP/PHP
Main: 203-789-4288
Fax: 203-867-5213

When completing this form in Word, please BOLD or UNDERLINE the appropriate multiple-choice responses. Free text sections will expand automatically. If completing the form by hand the writing must be legible or referral will not be accepted. Completed forms can be faxed to 203-867-5213.

Referral Information		
Date of Referral:	**Referring Provider:**	
Referring Agency:	**Telephone:**	**Email:**

Identifying Information			
Child's Name:		**DOB:**	**Age:**
Assigned Sex:	**Gender Identity:**	**Preferred Pronouns:** They/Them She/Her He/ Him	
Home Address:			
Primary Insurance:		**Insurance ID:**	
Secondary Insurance (if applicable):		**Insurance ID:**	
Parent(s)/Caregiver(s) Name:		**Phone:**	
Household members:			
Custody/visitation status:			
Primary language of child:		**Primary language of parent/caregiver:**	
Transportation arrangement to/from program:			
Has referral been discussed with child and parent/caregiver? Yes No			

Medical Information		
Pediatrician:	**Phone:**	
Medical Diagnosis:	**Allergies:**	
Medications:	**EpiPen:** Yes No	**Inhaler:** Yes No

Department of Children and Families		
DCF Involvement: Current Past None	**Area Office:**	
Worker:	**Phone:**	**Email:**
Supervisor:	**Phone:**	**Email:**
Status: Investigations Treatment OTC Committed		

School Information		
School:	**Grade:**	**Supports:** 504 IEP
Social Worker:	**Phone:**	**Email:**
Peer Concerns:		
Behavioral Concerns:		
Academic Concerns:		

Treatment History		
Current Therapist:	**Phone:**	**Email:**
MD/ DO/ APRN:	**Phone:**	**Email:**
DSM V Diagnoses:		
Length of time in treatment with current provider:		**Will child return after IOP?** Yes No
Past Treatment: IOP EDT IICAPS MDFT FAM Program Other:		
Pediatric ED Visits/ Evaluations: Yes No	**Location:** YNHH Bridgeport Hartford Healthcare Other	
Psychiatric Inpatient Admissions: Yes No	**Location:** YNHH Winchester 1 Other:	
Date(s) of Admission:		
Clinical Concerns: Depression Anxiety Anger Trauma Self-Injurious Behavior Suicidal Ideation Suicide Attempt(s) Aggression/ Harm Towards Others Destruction of Property Psychosis Peer Problems Gender Identity Sexuality Family Conflict Co-Parenting Issues		
Response to treatment: Worsening Symptoms No Change Minimal progress		
Engagement: Non-verbal Minimal Engagement Moderate Engagement Engages with Support		
Reason for Referral to IOP:		