DCF-4100
Rev. 08/2014

The Village
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Send this completed form to:
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EXTENDED DAY TREATMENT REFERRAL FORM
(see instructions attached to this form)

Date Received By:
DCF Gatekeeper:
EDT Program:

REFERRAL SOURCE: (Check One)		
☐ DCF SW:	Office:	Telephone: - -
☐ DCF Supervisor:	Office:	Telephone: - -
☐ System of Care Coordinator:		Telephone: - -
☐ Community Collaborative:		Telephone: - -
☐ Other Name:	Agency:	Telephone: - -

REQUESTED EDT PROGRAM:

REASON FOR REFERRAL:

DEMOGRAPHICS		
Child's Name:	Gender: ☐ Female ☐ Male	DOB:
Address:		Telephone: - -
City:	State:	Zip Code:
SS#:	Child's DCF Link Number:	
Child's Primary Insurance:		ID#:
Child's Secondary Insurance:		ID#:
Primary Language: Parent/Caregiver:		Child:
Secondary Language: Parent/Caregiver:		Child:
Parent/Caregiver's Name:		
Address:		
Telephone: Home: - -	Work: - -	

PARENT/CAREGIVER'S RELATIONSHIP TO CHILD				
☐ Parent	☐ Foster Parent	☐ Guardian	☐ Relative	☐ Other:

Have the caregivers been informed about the requirements for family involvement? ☐ Yes ☐ No

PERSONS LIVING IN THE HOME WITH CHILD:

NAME	GENDER	DATE OF BIRTH	RELATIONSHIP TO CHILD

ETHNICITY (Check One):				
☐ Asian American	☐ Pacific Islander	☐ Hispanic/Latino	☐ Black	☐ White
☐ Native American	☐ Other			

CHILD'S CURRENT DCF STATUS (Check One):		
☐ Dual Commitment	☐ Committed Abuse/Neglect/Uncared for	☐ Committed Delinquent
☐ Family with Service Needs	☐ Voluntary Services	☐ No Involvement
☐ Protective Services (Intake)	☐ Active (In Home CPS Case)	

CHILD'S MENTAL HEALTH/MEDICAL ISSUES		
CURRENT DSM-5 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			
NAME OF PROVIDER/AGENCY	TYPES OF SERVICES	DATES OF SERVICES	TELEPHONE NUMBER

Child's Psychiatrist:	Telephone Number:
Child's Therapist:	Telephone Number:
DESCRIBE ANY CURRENT MEDICAL PROBLEMS:	
Does the child take any medications? ☐ Yes ☐ No ☐ Unknown (Meds for physical or behavioral health reasons)	
If yes, please list the medications, if known.	
Child's Pediatrician:	Telephone Number:
OTHER AGENCIES/PROGRAMS INVOLVED WITH CHILD AND SERVICES PROVIDED:	

COLLATERAL CONTACTS	
Name of School:	Town:
Contact Person:	Telephone Number:
Special Education: ☐ Yes ☐ No	Full Scale IQ (If Known):
Probation/Parole Officer: ☐ Yes ☐ No	
Contact Person:	Telephone Number:

TRAUMA HISTORY	
HAS THE CHILD BEEN EXPOSED TO ANY OF THE FOLLOWING TRAUMATIC EXPERIENCES? (CHECK ALL THAT APPLY)	
Physical Abuse: ☐	Community Violence or Victimization: ☐
Sexual Abuse: ☐	Significant Loss (Attachment Disruptions/Multiple Placements) ☐
Domestic Violence: ☐	Unknown: ☐

PRESENTING CONCERNS

Please indicate behaviors that the child demonstrates on the chart below. If necessary, please elaborate or add additional concerns on a separate sheet.

SYMPTOMS	CURRENT	HISTORY	EXPLANATION OF CHECKED ITEMS
Self-injurious	☐	☐	
Aggressive Towards Others	☐	☐	
Destroying Property	☐	☐	
Psychotic Symptoms	☐	☐	
Suicidal Ideation	☐	☐	
Homicidal Ideation	☐	☐	
Sexualized Behaviors	☐	☐	
Stealing	☐	☐	
Lying	☐	☐	
Temper Tantrums	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Running Away	☐	☐	
Truancy	☐	☐	
Substance Abuse	☐	☐	
Cognitive Limitations	☐	☐	
Developmental Delays	☐	☐	
Bedwetting/Soiling	☐	☐	
Other	☐	☐	

PLEASE DESCRIBE CHILD'S STRENGTHS (Interpersonal, Community Interests, Other)

DCF SOCIAL WORKER OR SYSTEM OF CARE COORDINATOR
If available at or prior to the intake interview, please provide past treatment records, reports, and evaluations.

Signature of Referring Source Date:

Signature of DCF Liaison/Gatekeeper Date:
(For DCF Referrals)

Extended Day Treatment
Referral Form
DCF-4100

Instructions

The Extended Day Treatment (EDT) referral form (DCF-4100), was developed by the EDT Practice Standards Committee is to be used by all professionals who wish to make a referral to any of the state's contracted programs. This includes DCF staff, System of Care Coordinators, school personnel, hospital staff, treatment providers, residential staff and others. (Parents, guardians or relatives who are making direct referrals are not expected to use this form.) The form will be readily available within the communities and may be obtained from the respective EDT providers. The form may be completed electronically and e-mailed to the provider or the form may be completed manually and mailed or hand-delivered to the program site.

1. **Date Received By**

    a) For DCF-involved cases, the DCF Gatekeeper will record the date that the completed referral form was received from the Social Worker or Supervisor.
    b) For all referrals, the EDT provider will record the date of receipt of the referral form.

2. **Referral Source**
   Check the appropriate box to designate the referring agent.
   Provide the name, office or agency, and telephone number of the referring agent.

3. **Requested EDT Program**
   Identify the name of the EDT program.

4. **Reason for Referral**
   Briefly explain why the child needs an intermediate level of care.

5. **Demographics**
   Complete each item.

6. **Parent/Caregiver's Relationship to Child**
   Check the appropriate box. If other, please specify the nature of the relationship.

7. **Have the Caregivers been Informed about the Requirements for Family Involvement?**
   Answer yes or no, as applicable.
   Although the referring agent may not be aware of the detailed requirements, it is important to inform families immediately that their participation in treatment planning and service delivery is expected and an integral part of the program.

8. **Persons Living in the Home with Child**
   List each person who resides in the home and specify gender, date of birth and relationship to child.

9. **Ethnicity**
   Check the appropriate box.

10. **Child's Current DCF Status**
    Check the appropriate box.

11. Child's Mental Health/Medical Issues

Indicate the date of the most current diagnosis, and the treating provider.
Complete Axes 1 through V.

12. Current/Past Behavioral Health Treatment Providers/Agencies

List each provider and agency, types of services, dates of services, and telephone numbers.
Provide the names and telephone numbers for the child's psychiatrist and therapist, as applicable.

13. Describe any Current Medical Problems

Briefly describe any current physical health issues.
Check whether or not the child takes any type of medication for physical or psychiatric health issues. If yes, list all medications.
Provide the name and telephone number of the child's pediatrician.

14. Other Agencies/Programs Involved with Child and Services Provided

List any other involved agencies or programs and identify the services provided.

15. Collateral Contacts

Answer each item. Identify contacts, as applicable. Specify IQ, if known.

16. Trauma History

Check all the boxes that are applicable.

17. Presenting Concerns

Check the appropriate boxes that describe symptoms or behaviors, indicating current or past, or both, and explain the nature of these concerns, as necessary.

18. Please Describe Child's Strengths

Identify the child's assets such as talents, interests, interpersonal skills, etc.

19. Signature of Referring Source

Referring agent must sign and date the form.

20. Signature of DCF Liaison/Gatekeeper

For DCF-involved cases, the DCF Liaison/Gatekeeper must sign and date the form.

21. DCF Social Worker or System of Care Coordinator

If available at or prior to intake, please provide any pertinent treatment records, reports and evaluations.