Short-term Family Integrated Treatment (S-FIT)
Referral Form

Please fax completed S-FIT referral form to CTBHP Residential Care Team (855-584-2172).

REFERRING PARTY CONTACT INFORMATION	
Referring Party Name:	Phone:
	Email:
Referring Party Affiliation:	Agency Name:
DCF Area Office:	
DCF Case Worker:	Phone:
DCF Supervisor:	Phone:
DCF PS:	Phone:
DCF RRG:	Phone:
Probation Officer:	Phone:
Probation Supervisor:	Phone:

DEMOGRAPHICS				
Client Name:			Admission Date:	
Gender:			DCF Status:	
Ethnicity:				
Asian American	Pacific Islander	Hispanic/Latino	Black	White
Native American	Other			
Date of Birth:			Child ID Link#:	
Medicaid #:			Case ID Link#:	
Private Insurance Company:				

Placement type:

◆ _____ is being referred to S-FIT due to complex behavioral health service needs and has been assessed as requiring brief out of home care by members of their helping system. This includes: children and youth facing a potential psychiatric hospitalization; referral to an emergency room; or disruption from their current family context. The Contractor will likely encounter a variety of special needs including medical and mental health concerns, and potential high-risk behaviors. The target length of stay for children and youth engaged in S-FIT is 15 days or less.

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PARENT/CARETAKER	
Primary caretaker name:	Home/Cell phone:
	Work phone:
	Address:
Relationship to child: ☐ Parent ☐ Foster ☐ Guardian ☐ Relative ☐ Other	
Have caregivers been informed about requirements for family involvement?	

SCHOOLING AND COLLATERAL CONTACTS	
School Name:	Phone:
	Address:
Grade:	
Special Education:	IEP Classification:
504 Plan:	Full Scale IQ (If Known):
School transport:	Phone:
Probation/Parole Officer:	Phone:
Extracurricular Program:	Phone:

REASON FOR REFERRAL:

DISCHARGE PLAN:

DIAGNOSES	
Code:	Diagnosis:
Code:	Diagnosis:
Code:	Diagnosis:
Code:	Diagnosis:

MEDICATIONS			
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

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TRAUMA HISTORY		
Has the child been exposed to any of the following traumatic experiences?		
Physical Abuse	Witness Domestic Violence	Community Violence
Sexual Abuse	Significant Loss	Serious Accident/Injury
Neglect	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.

Behavior	Current	History	Explanation
Self-Injury	☐	☐	
Aggression Towards Others	☐	☐	
Property Destruction	☐	☐	
Hallucinations/Delusions	☐	☐	
Suicidal Ideation	☐	☐	
Homicidal Ideation	☐	☐	
Sexualized Behavior	☐	☐	
Stealing	☐	☐	
Lying	☐	☐	
Temper Tantrums	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Running Away	☐	☐	
Truancy	☐	☐	
Substance Abuse	☐	☐	
Cognitive Limitations	☐	☐	
Developmental Delays	☐	☐	
Bedwetting	☐	☐	
Other	☐	☐	

Signature of Referring Source **Date**

Signature of DCF Liaison/Gatekeeper **Date**