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: Choose an item		Agency Name:	
DCF Area Office: Choose an item			
DCF Case Worker:		Phone:	Fax:
DCF Supervisor:		Phone:	
DCF PS:		Phone:	
DCF RRG:		Phone:	
Probation Officer:		Phone:	
Probation Supervisor:		Phone:	

DEMOGRAPHICS				
Client Name:			Admission Date:	
Gender:			DCF Status: Choose an item	
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? ☐ yes ☐ no	

SCHOOLING AND COLLATERAL CONTACTS	
School Name:	Phone:
	Address:
Grade:	
Special Education: ☐ yes ☐ no	IEP Classification:
504 Plan: ☐ yes ☐ no	Full Scale IQ (If Known):
School transport:	Phone:
Probation/Parole Officer:	Phone:
Extracurricular Program:	Phone:
School transportation to be provided by:	

CURRENT PROVIDER CONTACTS	
Prescribing Medical Doctor:	Phone:
Therapeutic treatment provider:	Phone:

REASON FOR REFERRAL: (presenting issue, how can family benefit)

CURRENT TREATMENT SERVICES: (current treatment services and provider, current prescribing MD)

DISCHARGE PLAN: (pending referrals, treatment plan for time of discharge, discharge residence)

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

MEDICATIONS (psychiatric, medical, emergency medications with dosages)

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**