carelon
Behavioral Health

Community Pathway Program Referral Form

Please fax referral to 860-707-1003 or email cpathways@carelon.com

Referral Information

***Please Note: If the child/family has DCF involvement, contact the DCF worker to make program referral.**

Referral Source:	**Program Referring to:**
☐ Family ☐ Community Provider ☐ State Agency ☐ School ☐ Other	
Referral Contact Person:	**Date of Referral:**

Relationship to Child/Youth:			
Agency Name (if applicable):			
Email Address:		**Phone Number:**	

Child Demographic Information

Child's Name (First, Middle, Last):	**Date of Birth:**

Other Name(s) (if applicable):	
Street Address:	

City:	**State:**	**Zip Code:**

Gender:	**Ethnicity:**	**Race:**	**Primary Language (Specify):**

Healthcare Insurance Carrier:		**Insurance ID:**
Primary:		
Secondary:		

School Name:	**Current Grade:**	**Special Education:**
		☐ N/A ☐ 504 ☐ IEP

Parent/Legal Guardian Information

Primary Parent/Legal Guardian Name:	**Relation to the child:**	**Parent/Legal Guardian Date of Birth:**

Gender:	**Ethnicity:**	**Race:**	**Primary Language (Specify):**

Street Address:	**City:**	**State:**	**Zip Code:**

carelon Behavioral Health

Primary Phone:	Email Address:

Secondary Parent/Legal Guardian Information, as applicable

Primary Parent/Legal Guardian Name:	Relation to the child:	Parent/Legal Guardian Date of Birth:

Gender	Ethnicity:	Race:	Primary Language (Specify):

Street Address:	City:	State:	Zip Code:

Primary Phone:	Email Address:

Child's Treatment Involvement

Involvement with Dept of Development Services?	Current Legal Involvement?
☐ Yes ☐ No	☐ Yes ☐ No

Current Providers and Other Team Members for the Child

Agency	Contact Person	Role	Contact Number

List of Active Referrals Already Made for the Child:

Child's Behavioral Health, Mental Health, and Medical History/Reason for Referral

Behavioral/Medical History		
Behavioral Health	**Past 3 months**	**History of**
Self-Mutilation	☐	☐
Trauma	☐	☐

Reason for Referral (Please briefly state the reasons for the referral):

Suicidal Behaviors	☐	☐
Assaultive Behaviors	☐	☐
Threatening Behaviors	☐	☐
Damage to property (own/others)	☐	☐
Depression	☐	☐
Excessive Fear/Anxiety	☐	☐
Substance Use	☐	☐
Runaway Behaviors	☐	☐
Night Terrors	☐	☐
Bed Wetting	☐	☐
Soiling	☐	☐
Sexually Reactive or offending	☐	☐
Fire-setting	☐	☐
Hurting Animals	☐	☐
Medical Health		
Significant Medical Problems	☐	☐
Hearing Impairment	☐	☐
Vision Impairment	☐	☐
Physical Disability	☐	☐
Brain Injury	☐	☐
Pregnancy	☐	☐
Other		
School Avoidance/Truancy	☐	☐
Developmental Delay (IQ<70)	☐	☐
Legal Involvement		
Any Arrests	☐	☐
Stealing	☐	☐

Current Diagnoses of the Child:

Treatment History (Please identify any past treatment that the youth has had, as well as the outcome of the treatment):