Child Name: _____

IICAPS Site: Community Child Guidance Clinic

Please FAX completed form to IICAPS Director at 860-645-1470

IICAPS Referral and Critical Information Form

Date of Referral	Insurance	Insurance #

Referral Source	Telephone	Fax Number	Date of Discharge From referral source

Child's Name	Current Address (must include zip code with address)	D.O.B.	Age	M/F

Is the Child of Hispanic Origin? (Select only one):	No, Not of Hispanic, Latino or Spanish Origin Yes, Mexican, Mexican-American, Chicano Yes, Puerto Rican Yes, Cuban Yes, South or Central American Yes, of Hispanic/Latino Origin
Child's Race: (Circle/Highlight all that apply):	American Indian or Alaska Native Asian Black or African-American Native Hawaiian or other Pacific Islander White Other

Family Telephone Numbers:

Work	Home	Primary Language:
		Of Child: **Of Caregivers:**

Yes	No	DCF Past Worker	Phone#
Yes	**No**	**DCF Current Worker**	**Phone#**

Residing with and Relationship to IP	Guardian	Guardian's DOB

Mother's Name	Age	D.O.B.	Phone	Race/Hisp. Origin (use options listed above)

Father's Name	Age	D.O.B.	Phone	Race/Hisp. Origin (use options listed above)

Child's School	Grade	Special Ed. Yes/No	School Contact

Other Household Members:

Name	Age	D.O.B.	Race/Hisp. Origin (use options listed above)	School	Relationship to patient

Reason for Referral (box will expand on electronic format):

Behaviors of Concern:

Child Domain (topics might include presentation, behaviors, coping skills, cognitive abilities, etc):

Child/Family Domain (topics might include relationships within the family, parenting styles, history, crises management):

Child/School Domain(topics might include academic, behavioral, or social concerns):

Child/Physical Environment/Systems Domain (topics might include important service providers involved with the family, community support available, other systems' involvement like DCF/CSSD):

What do you want IICAPS to work on with this child/family?:

Diagnosis (Include Codes):

I	
II	
III	
IV	
V CGAS	

Current Medications:

Name	Dose	Frequency	Prescriber

Past Medications:

Name	Dose	Frequency

Past Psychiatric Hx: (include information about psychiatric hospitalizations (place of admission, dates, reason for admission) as well as other forms of mental health treatment provided to child.

Medical History (hospitalizations, medical conditions or concerns):

Current Treaters:

Family Member Receiving Service	Institution/Agency	Type of Service (individual therapy, inpatient, outpatient)	Telephone #	Name of Contact

Past Treaters:

Family Member Receiving Service	Institution/Agency	Type of Service (individual therapy, inpatient, outpatient)	Telephone #	Name of Contact

IICAPS Coordinators are reminded to enter data into the IICAPS Web-based system (BMS) promptly. Any cases not accepted should document the reason for rejection and more appropriate programs within the "Reason for Rejection" box on the Main Episode of Care Screen.