CONNECTICUT JUNIOR REPUBLIC
WELLNESS CENTER FOR CHILDREN AND FAMILIES
REFERRAL FORM

Client Information

Name____ DOB__________________

Street Address______________________________________ SS#____________________

City/State________________________ Zip______________ Gender_________________

Parent/Legal Guardian Name____________________________

Preferred Phone Daytime or Cell ________________________ ______________________

Does client reside with Legal Guardian? ☐Yes ☐No

If No, where does client reside?____

Race_________________________________

Primary Language ☐English ☐Spanish ☐Other, Specify:___________________________

Appointment Availability and Office Preference ____________________________________

Insurance Information

Subscriber/Insured Name____

Subscriber/Insured SS#________________________________

Insurance Company Name____

Insurance Benefits Phone #_____________________________

Policy#________________________________ Group #_____________________________

Plan #_________________________________ ID#_________________________________

Does policy holder give permission to verify insurance __Yes __No

Client's Primary Care Physician Name/Phone____

Referring Provider Information (If Not Parent or Guardian)

Referral Name ____

Agency____

Office Phone___________________________ Office Fax_____________________________

Referral Information

Services Requested ☐Individual Therapy ☐Family Therapy ☐Group Therapy
☐Psychiatric Evaluation

List the key concerns to be addressed ____

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Current Diagnosis (if present)____

List of current medications____

Treatment History____

Is client involved in any other CJR Services? ☐Yes ☐No

If Yes, what program/location?____

Is there DCF involvement? ☐Yes ☐No

If Yes, name of assigned worker____

Phone____

Is treatment mandated by DCF? ☐Yes ☐No

Is there Court Involvement? ☐Yes ☐No

If Yes, name of Probation/Parole Officer____

Phone____

Is treatment court ordered? ☐Yes ☐No

Charges____

For Completion By Clinic Director of CJR Wellness Center for Children and Families

Date Received__________________ Therapist Assigned/Location_______________________

Date Assigned__________________ Scheduled Intake Assessment Date__________________

Reason client not scheduled____

☐ Referral information has been reviewed, and our available services do not best meet the needs of the client. Comments and date that referring party was notified that referral was not accepted.

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