Child Trauma Services Program (TF-CBT)

OU Children's Physicians
Developmental and Behavioral Pediatrics
1100 NE 13th Street, Oklahoma City, OK, 73117
(405) 271-5700, ext. 45149; [referral fax] (405) 271-8835

REFERRAL FORM

CHILD INFORMATION

Child's Name: ______________________ **Date of Referral:** ______________

Sex: ☐ Male ☐ Female **Social Security Number:** ______________

Date of Birth: __________ **Age:** __________ **[CTS Use Only] MRN:** ______________

Legal Guardian: ☐ Parent ☐ Kinship ☐ Oklahoma Department of Human Services ☐ Indian Child Welfare
☐ Other: ______________________

Complete if DHS/ICW is legal guardian or currently involved with child

DHS/ICW Worker Name: ______________________ **County:** ______________

Office Address: ______________________

Office Phone: ______________ **Cell Phone:** ______________

Fax: ______________ **Email:** ______________

Supervisor's Name: ______________ **Supervisor Contact Phone:** ______________

REFERRAL SOURCE INFORMATION – ☐ If caregiver, then skip this section.

Referral Source Name: ______________________

Agency (if applicable): ______________________

Relationship to Child: ______________________

Address: ______________________

Home Phone: ______________ ☐ Leave message **Cell Phone:** ______________ ☐ Leave message

Work Phone: ______________ ☐ Leave message **Fax:** ______________

Email: ______________________

CAREGIVER INFORMATION

Primary Caregiver Name: ______________________

Placement Type: ☐ Birth / Adoptive Parent ☐ Kinship (non-foster care) ☐ Legal Guardian ☐ Foster care
☐ Kinship foster care ☐ Therapeutic foster care – Agency: ______________

Relationship to Child: ______________________

Address: ______________________

Home Phone: ______________ ☐ Leave message **Cell Phone:** ______________ ☐ Leave message

Work Phone: ______________ ☐ Leave message **Fax:** ______________

Best Times to Call: ☐ Morning ☐ Afternoon ☐ Evenings ☐ Other: ______________

Email: ______________________

[Office Use Only]	Provider/Supervisor:	Intake Date:	Intake Time:

CHILD TRAUMA HISTORY

Has Child Experienced a Traumatic Event? ☐ Yes / Suspected* – Complete below (check all that apply) ☐ No

☐ Physical abuse ☐ Sexual abuse ☐ Neglect ☐ Psychological / Emotional

☐ Weather disaster ☐ Accident ☐ Witnessing intimate partner violence (IPV) / Domestic violence (DV)

☐ Community violence ☐ Medical Procedure / Illness ☐ School violence ☐ War/terrorism

☐ Other: ______________________________

Details:

Has Child Completed a Forensic Interview? ☐ Yes ☐ No, but will complete ☐ No, not needed ☐ Unsure

Concerns about Child (check all that apply) ☐ No identifiable problems; child appears to be functioning well

☐ Not minding ☐ Moody / Sad ☐ Hyperactivity ☐ Sleep problems / Nightmares

☐ Self-harm ☐ Low self-esteem ☐ Anger / Aggression ☐ Bothersome memories

☐ Somatic complaints ☐ Anxiety / Fear ☐ Poor school performance ☐ Overwhelming grief

☐ Wetting / Soiling self ☐ Sexualized behavior

☐ Problematic interactions with friends ☐ Problematic interactions with caregivers

☐ Risk taking behaviors: ______________________________

☐ Other – Explain: ______________________________

Details:

Currently Receiving Counseling or Therapy? ☐ Yes – Complete below. ☐ No ☐ Unsure

- **Provider's name and phone number:** ______________________________

INSURANCE – ☐ If child does not have insurance, then skip this section.

Primary Insurance		**Secondary Insurance – ☐ None**	
Insurance Carrier:		**Insurance Carrier:**	
Policy Holder:		**Policy Holder:**	
Holder's DOB:		**Holder's DOB:**	
Policy Number:		**Policy Number:**	
Contact Phone:		**Contact Phone:**	
Employer:		**Employer:**	

Primary Care Physician: ______________________ **Office Phone:** ______________________

Submit completed forms to the DBP referral fax at (405) 271-8835, ATTN: Amanda Mitten. Ms. Mitten will contact the parent/legal guardian for additional information and make arrangements for an intake assessment for the child.

Questions - Contact the CTS Program Coordinator at (405) 271-5700, extension 45149.