Child Trauma Services Program

OU Health Children's Physicians
Developmental and Behavioral Pediatrics
1100 NE 13th Street, Oklahoma City, OK, 73117

Family TREE
5909 N. Classen Ct.
Oklahoma City, OK 73118

(572) 244-0059 ext. 85051035; [referral fax] (572) 244-9830

REFERRAL FORM

Services Offered:

- **Trauma-Focused Cognitive-Behavior Therapy (TF-CBT)**
- **TF-CBT Group Program**
- **Alternatives for Families: A Cognitive-Behavior Therapy (AF-CBT)**
- **Parent-Child Interaction Therapy (PCIT)**
- **Attachment & Biobehavioral Catch-Up (ABC)**

CHILD INFORMATION

Child's Name: _____ **Date of Referral:** _____

Gender: ☐ Male ☐ Female ☐ Other **Date of Birth:** _____ **Age:** _____

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

Complete if DHS is legal guardian or currently involved with child

DHS Worker Name: _____ **County:** _____

Office Address: _____

Office Phone: _____ **Cell Phone:** _____

Fax: _____ **Email:** _____

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

CAREGIVER INFORMATION

Primary Caregiver Name: _____

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

Relationship to Child: _____

Address: _____

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

Work Phone: _____ ☐ Leave message

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

Email: _____

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

Referral Source Name: _____

Agency (if applicable): _____

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

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

Email: _____

CHILD'S TRAUMA HISTORY

Has Child Experienced a Traumatic Event? ☐ Yes – Complete below ☐ No

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

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

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

☐ Child Pornography ☐ Bullying ☐ Kidnapping ☐ Hate Crime ☐ Survivor of Homicide

☐ Teen Dating Victimization ☐ Violation of Court Order ☐ Robbery ☐ DUI/DWI ☐ Other Vehicular

☐ 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 ☐ Grief

☐ Wetting / Soiling self ☐ Sexualized behavior

☐ Problems with friends ☐ Problems 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 (572) 244-9830, ATTN: Hannah Frye or email forms to childstudycenterreferrals@ouhealth.com. Ms. Frye will contact the parent / legal guardian for additional information and make arrangements for an intake assessment for the child.
Questions - Contact Hannah Frye at (572) 244-0059 extension 85051035.