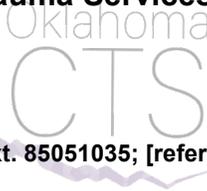


Child Trauma Services Program

OU Health Children's Physicians
Developmental and Behavioral Pediatrics
1100 NE 13th Street, Oklahoma City, OK, 73117
(572) 244-0059 ext. 85051035; [referral fax] (572) 244-9830



Family TREE
5909 N. Classen Ct.
Oklahoma City, OK 73118
(572) 244-9830

REFERRAL FORM

Services Offered:	<input type="checkbox"/> Trauma-Focused Cognitive-Behavior Therapy (TF-CBT)	<input type="checkbox"/> Alternatives for Families: A Cognitive-Behavior Therapy (AF-CBT)
	<input type="checkbox"/> TF-CBT Group Program	<input type="checkbox"/> Parent-Child Interaction Therapy (PCIT)
	<input type="checkbox"/> 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: _____

Policy Holder: _____

Holder's DOB: _____

Policy Number: _____

Contact Phone: _____

Employer: _____

Insurance Carrier: _____

Policy Holder: _____

Holder's DOB: _____

Policy Number: _____

Contact Phone: _____

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.