

# 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



## OKDHS REFERRAL FORM

Services Offered:	<ul style="list-style-type: none"><li>Trauma-Focused Cognitive-Behavior Therapy (TF-CBT)</li><li>TF-CBT Group Treatment Program</li><li>Attachment &amp; Biobehavioral Catch-Up (ABC)</li></ul>	<ul style="list-style-type: none"><li>Alternatives for Families: A Cognitive-Behavior Therapy (AF-CBT)</li><li>Parent-Child Interaction Therapy (PCIT)</li></ul>
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### 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: \_\_\_\_\_

### FOSTER PARENT/CUSTODIAL 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: \_\_\_\_\_

### WORKER INFORMATION

Check all that apply:  OKDHS  ICW  OJA  JB

Worker Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_      Cell Phone: \_\_\_\_\_

Fax: \_\_\_\_\_      Email: \_\_\_\_\_

Supervisor's Name & Number: \_\_\_\_\_

### CHILD'S PLACEMENT PLAN

What is the Current Permanency Plan?  N/A  Unknown  Reunification  Adoption  
 If reunification or adoption, indicate timeline: \_\_\_\_\_

Are the biological mother's parental rights terminated?  Yes  No  Unknown  N/A

Are the biological father's parental rights terminated?  Yes  No  Unknown  N/A

**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

Insurance Carrier: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Holder's DOB: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_

Secondary Insurance –  None

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](mailto: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.