Catholic Charities

Children's Behavioral Health Home
Referral Form

Referral Date: _____ **Youth Name**: _____

Gender: **M** **F** **Race**: _____ **DOB**: _____ **Age**: _____

SS #: _____ **Maine Care #**: _____

Parent Name: _____ **Address:** _____
(Street, City, State & Zip)

Phone #: _____ **Cell #**: _____ **Work #**: _____

Guardian Name: _____ **Address:** _____
(Street, City, State & Zip)

Family Size: _____

Phone #: _____ **Cell #**: _____ **Work #**: _____

Is the child currently receiving Case Management or BHH services? ☐ **Yes** ☐ **No**

How did you hear about us? _____

Referral Source: _____
(Include Provider Name, Agency Name, Address & Phone #)

Diagnosis (Axis I & II): ☐ **Verified** ☐ **Not Yet**

_____ _____ _____
(Diagnoses) **(Source)** **(Date)**

School Name: _____ **Grade:** _____

Is the child receiving Special Education services? ☐ **Yes** ☐ **No**

What's going on? (how are things at home, school, etc.) _____

_____

_____

_____

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Are there any developmental delays: (speech, social skills, toileting) **If yes, please explain**: _____

_____

_____

Have there been any emergency/crisis issues recently? **If yes, please explain**: _____

_____

_____

What can our services do to help? (make referrals, school support, behavior management, etc.) _____

_____

_____

_____

Who is currently working with the family?

Primary Care Physician (required): _____

Therapist: _____

Psychiatrist: _____

Medical Specialist: _____

In-Home Support: _____

DOC-Probation: _____

Other: _____

_____

Is there currently DHHS involvement? **If yes, please explain**. _____

_____

_____

Signature of Person Completing Form: _____ **Date:** _____