Complex Trauma Referral Cover Sheet

Referral of a Child/Youth with Complex Trauma as a Single Qualifying Condition in order to Establish Eligibility for Health Home.

Required Information

Child's Name:
DOB:
Child's Current Address:
Medicaid #:

Referral Source Name:
Agency (if appropriate):
Address:
Phone:

Relationship:

Parent/Guardian Name:
Address:
Phone:

Medical Consent: (if Different)
Name:
Address:
Phone:

Date of Referral:

Complex Trauma Exposure Screening Form (attach screen)

Completed By:
Date of Screening:

Reason for Referral (Brief narrative, please include any details on events, behaviors, etc. that prompted the referral):

_____

_____

_____

_____

Optional/Desired Information

Completion of this cover sheet and the complex trauma exposure screen is sufficient for referral.
Providing the following information may facilitate timeliness of the referral.

Last School Attended
Name:
Address:
Contact Person:

Behavioral Health
Provider Name:
Address/Phone:
Contact Person:

Foster Care / DCYF
County / Agency Name:
Address / Phone:
Contact Person:

Other Collateral
Provider Name:
Address / Phone:
Contact Person:

Primary Care / Pediatrician
Name:
Address / Phone:

Attached Documentation
Psychiatric
Psychological
Medical / Physical
School Information
Other: