

Complex Trauma Referral Cover Sheet

For 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 #:

Parent/ Guardian Name:

Address:
Phone:

Medical Consent (if different)

Name:
Address:
Phone:

Referral Source 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 event, 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:

Foster Care/ DCYF

County/ Agency Name:
Address/ Phone:
Contact Person:

Primary Care/ Pediatrician

Name:
Address/Phone:

Behavioral Health

Provider Name:
Address/Phone:
Contact Person:

Other Collateral

Provider name:
Address/ Phone:
Contact:

Attached Documentation

Psychiatric
Psychological
Medical/ Physical
Other: _____