UCONN HEALTH

HomeCare Initial Referral

Program Director: Beth Muller, PMHNP, PMHCNS, APRN, bmuller@uchc.edu
Please fax or email completed referral and consent forms to Mary Weigel at 860.679.4631, mweigel@uchc.edu
PHONE: 860.679.3938, FAX: 860.679.4631, MAIN EMAIL: homecareprogram@uchc.edu

HC USE ONLY: **Accepted Date of Referral: _____** **Homecare ID #: _____**

DEMOGRAPHIC DATA

Juvenile Justice ID #: CL_____DOB:_____DCF Involvement: ☐ Yes ☐ No
DCF Worker: _____ Phone: _____ DCF Custody: ☐ Yes ☐ No

Client Name:_____Current Placement: _____

Age:_____Gender:_____Ethnicity:_____Primary Language - Child/Parent: _____

Current Address: _____

City:_____State: CT Zip:_____

Parent/Guardian Name:_____Home Phone: _____

Address, if different:_____

Home Email: _____ Cell Phone: _____

REFERRING PROBATION OFFICER

Name:_____Court Location (City): _____

Email:_____Phone #_____Ext: _____

Detention Data: ☐ In Detention ☐ On Probation, Past Detention ☐ On Probation, No Past Detention ☐ FWSN
Detention Location:_____Admission Date:_____Discharge Date: _____

MEDICAL DATA

Currently on Medications: ☐Yes ☐No If yes, please list: _____

Past Medications: _____

Insurance Name:_____Insurance Phone #: _____

Insurance Policy #:_____NOT INSURED – Please check here: ☐

Primary Care Provider:_____Substance Use/Abuse Hx: ☐ Yes ☐ No

SCHOOL DATA

Current School:_____Contact:_____Grade:_____Special Ed: ☐Yes ☐No

☐ Please attach all reports pertaining to this client including: Charges, JJIE's, recent clinical evaluations.
☐ Please note any special accommodations the youth or family might need.