**Fathers for Change Clinical Trial**

Incoming Referral Form

**REFERRAL DATE**:      ­­­­

**SELECT SITE PREFERENCE:**

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| **[ ]**  | **Parent and Family Development Program***Yale University Child Study Center*350 George St., New Haven, CT 06510**Program Lead**: Dr. Carla S. Stover**Phone**: (844) 362- 9272**FAX:** (203) 737-1961 (preferred)**Email**: carla.stover@yale.edu | **[ ]**  | **Family Adversity & Resilience Research Program***UConn Health Department of Psychiatry*65 Kane St., West Hartford, CT 06119**Program Lead:** Dr. Damion Grasso**Phone**: (860) 523-6439**FAX:** (860) 523-3736**Email**: dgrasso@uchc.edu (preferred) |

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| **PARTICIPANT MUST MEET FOLLOWING CRITERIA**  |
| [ ]  Evidence of physical IPV in the last 18 months (e.g. pushing, shoving, property damage, thrown objects)[ ]  Has at least one child who is 3 months to 12 years old [ ]  English speaking[ ]  Has never threatened co-parent with firearm [ ]  Co-parent was not admitted to the hospital due to IPV incident [ ]  Never completed Fathers for Change or IPV-FAIR program in the past  |
| **PARTICIPANT INFORMATION (REQUIRED)** |
| Name:       | Date of Birth:        |
| Current Address:       |
| City:        | State:        | Zip code:       |
| Phone Home:        | Mobile:        | Work:       |
| Email:        | Number of children under the age of 18:       |
| Ethnicity:       | Primary Language:       |
| **REFERRAL SOURCE INFORMATION (REQUIRED)** |
| Referring Office:       | Name:       |
| Phone:       | Email:       |
| Supervisor (if applicable):       |
| Please use this section to describe in as much detail as possible the reason for the referral. Please include the following: (1) is there currently a protective order in place? If so, what kind and who does it include? (2) reason for DCF involvement? (3) Detailed description of IPV incident(s). When applicable, include IPV specialist evaluation.       |
| **CHILDREN INFORMATION (REQUIRED)** |
| **Name** (youngest first) | **Gender** | **Date of birth** | **Child living with referred parent?** |
| 1 |       | [ ]  Female | [ ]  Male | [ ]  Other |       | [ ]  Yes | [ ]  No |
| 2 |       | [ ]  Female | [ ]  Male | [ ]  Other |       | [ ]  Yes | [ ]  No |
| 3 |       | [ ]  Female | [ ]  Male | [ ]  Other |       | [ ]  Yes | [ ]  No |
| 4 |       | [ ]  Female | [ ]  Male | [ ]  Other |       | [ ]  Yes | [ ]  No |
| 5 |       | [ ]  Female | [ ]  Male | [ ]  Other |       | [ ]  Yes | [ ]  No |
| 6 |       | [ ]  Female | [ ]  Male | [ ]  Other |       | [ ]  Yes | [ ]  No |
| **COPARENT INFORMATION (REQUIRED)** |
| Co-Parent/Partner Name:       | Phone:       |
| Other phone:       | Email:       |
| Has DCF spoken to co-parent about this referral and program? [ ]  Yes [ ]  No [ ]  Will contact |
| (If Yes) Is co-parent willing to be contacted by our staff to learn more? [ ]  Yes [ ]  No [ ]  Unknown |
| **CURRENT PRIMARY CAREGIVER INFORMATION (e.g. kinship/foster parent)**IF NOT COPARENT OR REFFERED PARENT |
| Primary Caregiver Name:       | Phone:       |
| Other phone:       | Email:       |
| **ADDITIONAL FATHER INFORMATION** |
| Is father referred for or involved in other treatment: [ ]  Yes [ ]  NoIf Yes, describe:       |
| Other relevant information:      |

**\*\* PLEASE EMAIL OR FAX THIS FORM TO THE APPROPRIATE SITE\*\***