**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](mailto: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](mailto: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  No  If Yes, describe: | | | | | | | | | | |
| Other relevant information: | | | | | | | | | | |

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