University of Connecticut Health Center
The HomeCare Program

Department of Psychiatry
School of Medicine

CONSENT FORM FOR REFERRAL TO HOMECARE PROGRAM
THIS FORM MUST BE COMPLETED AND SENT IN WITH THE REFERRAL

Name of Youth: _____

Name of Parent
Or Legal Guardian: _____Phone:_____

Name of PO: _____Phone:_____

Probation Officer:

Please verify and check the following

☐ Referral was discussed with clinical coordinator OR made as part of formal evaluation

Referral for:

☐ Evaluation

☐ Medication Management Bridging Service (up to two months of care)

Please note who will provide psychiatric care after HomeCare Program:

Provider:_____ Phone:_____

Location:_____

Parent:

I, _____, agree to this referral to HomeCare Program, a short term
(Parent or Guardian Name)
psychiatric evaluation and clinical bridging program. In consenting to this referral, I agree to consider all recommended treatment, including possible psychotropic medication management. I agree to attend all scheduled appointments.

Signature of Parent: _____Date:_____

Youth:

I, _____, agree to this referral to HomeCare Program, and
(Youth Name)
agree to be cooperative and participate in the evaluation and recommended treatment. I agree to attend all scheduled appointments.

Signature of Youth: _____Date:_____