Strategic Resolutions LLC

"BUILDING A BETTER YOU!"

Services for Individuals, children and families

419 Whalley Ave Suite 309, New Haven, CT 06511
Office: (203) 823-9150 Fax: (203) 905-6809

Please circle the Service being requested:

Individual/Family Therapy **Clinical Assessments** **Family Preservation**

Date of Referral:		
Client Name:	**DOB:**	**Link #** (if applicable):
Insurance Id: (if applicable)		**Ethnicity:**
Street Address:		**City:**
Contact number(s):		
Employment status:	**Employer:**	
Marital Status:		

Client Child(ren):	**Insurance(If applicable)**	**DOB**	**Live w/Client Y or N?**

Requested Service Information:

DCF level of Involvement (circle one if applicable):

Protective Services Commitment Vol. Services OTC Intakes

Referring Worker Name: **Worker number:**

Referring Supervisor: **Supervisor number:**

Regional office:

Payment authorization approved: **Date:**

If this is a request for a non-billable service, please provide a payment authorization upon agreement of services to be rendered.

Client name & DOB:

Referral Type (Circle one):

Individual Therapy Family Therapy Couples Therapy Family Preservation Clinical Assessment

Referral Reason:

Diagnostic Impression:

Past hx of a diagnosis:

If no prior mental health issues, please indicate what the current symptoms:

Current/Past medications (List all and dosages)

Safety concerns: Yes or No

Any history of Domestic Violence, Substance Use, Neglect or Abuse?

Past history of mental health Treatment? IF yes, please explain.

Explain any history of hospitalizations, residential care, past legal involvement, out of home placements?
List of Providers:
Expected Goals/Objections
Barriers/Limitations

COMPLETED FORM CAN BE FAXED TO:
Strategic Resolutions LLC
203-905-6809
Or
Tgrey@strategicresolutionsct.com

THANK YOU!