

**Enfield Youth Service Bureau
19 North Main Street
Enfield, CT 06082
Phone: (860) 253-6380 Fax: (860) 253-5145**

Referral Form

Date of Referral: _____ Referral Source: _____

Name of Child: _____ D.O.B.: _____

Address: _____ City/State: _____

Name of Parent(s)/Guardian(s): _____

Home Phone Number: _____ Cell Phone Number: _____

School: _____ Grade: _____

Presenting Concerns:

Behaviors (frequency, intensity, duration and history): _____

Spheres affected (circle): home school socially

Previous Treatment History (family history, medications, prescribing MDs.): _____

Agency/Legal Involvement (contact person): _____

Who is living in the home: _____

Services Requested (circle): individual family group

Level of Risk: None Low Medium High Active

EYS Appropriate Level of Care (circle): Yes No

Recommendation/Worker Assigned: _____

Signature

Date