CHR School Based Referral Form - Killingly Public Schools

Please email referrals to Diane Reas LCSW, Clinical Supervisor (Dreas@chrhealth.org)

Date _____ **School**_____

Name _____ DOB _____

Gender circle one Female Male Other _____

Address_____

Parent/Guardian Name

_____

Phone _____

Email address_____

If no email address, why:

___Doesn't have one

___Prefers not to use

Primary Care Doctor/Pediatrician: _____

Insurance:

If Husky, ID: _____

If commercial: Name of Company: _____

ID Number _____

Group number _____

Phone number (Ask for a number for Mental Health or SA sxs, Provider services, precertification) _____

Policyholder's name _____

Policyholder's DOB _____

Policyholder's address _____

CHR USE ONLY

Date first contact with family: _____

Date first appt offered: _____ **Date first appt accepted:** _____