



Complex Trauma Referral Cover Sheet

Referral of a Child/Youth with Complex Trauma as a Single Qualifying Condition in order to Establish Eligibility for Health Home.

Required Information

Child's Name: Referral Source Name: Relationship:
DOB: Agency (if appropriate):
Child's Current Address: Address:
Medicaid #: Phone:

Parent/Guardian Name: Medical Consent: (if Different)
Address: Name:
Phone: Address:
Phone:

Date of Referral:

Complex Trauma Exposure Screening Form (attach screen)

Completed By:
Date of Screening:

Reason for Referral (Brief narrative, please include any details on events, behaviors, etc. that prompted the referral):

Four horizontal lines for writing the reason for referral.

Optional/Desired Information

Completion of this cover sheet and the complex trauma exposure screen is sufficient for referral. Providing the following information may facilitate timeliness of the referral.

Last School Attended

Name:
Address:
Contact Person:

Behavioral Health

Provider Name:
Address/Phone:
Contact Person:

Foster Care / DCYF

County / Agency Name:
Address / Phone:
Contact Person:

Other Collateral

Provider Name:
Address / Phone:
Contact Person:

Primary Care / Pediatrician

Name:
Address / Phone:

Attached Documentation

- Psychiatric
Psychological
Medical / Physical
School Information
Other: