

COMPREHENSIVE ASSESSMENT FOR TREATMENT (CAT) Referral Form

1. Case information

Referring Agency: _____ Referral Date: _____

Referent Name: _____ Referent Phone: _____

Referent Email: _____ Approving Supervisor's Email: _____

DCYF Referral Yes or No District Office (or NA): _____ Client ID: _____

Community or Department Involvement: Community Delinquency Abuse/Neglect CHINS Other _____

Court Date (If Applicable): _____ Child/Youth Information Sheet (Please check box if attached)

Expedited Referral Please check box if youth is currently detained, is currently psychiatrically hospitalized, was emergency court ordered and admitted to residential treatment program within 24 hours, has received a discharge notice from a foster family or a residential provider is currently in the emergency room for psychiatric reasons, other _____

Confirmation Assessment for youth who have had an assessment completed within the last 60 days

2. Child/Youth Information

Youth first name: _____ Middle Initial: _____ Last name: _____

Youth DOB: _____ Youth preferred pronoun (he/she/they/other): _____

Primary Insurance: _____ Medicaid ID (If applicable): _____

Youth preferred spoken language: _____ Interpreter needed?

Youth preferred written language: _____ Translator needed?

3. Youth Ethnicity

Is the youth of Hispanic, Latino/a, or Spanish origin? Yes No

If yes, which group describes his/her Hispanic, Latino/a, or Spanish origin? (Select all that apply)

Central American	<input type="checkbox"/>	Mexican or Chicano	<input type="checkbox"/>	Other Hispanic	<input type="checkbox"/>
Cuban	<input type="checkbox"/>	Puerto Rican	<input type="checkbox"/>	Declined (don't ask again)	<input type="checkbox"/>
Dominican	<input type="checkbox"/>	South American	<input type="checkbox"/>	Unavailable/unknown	<input type="checkbox"/>

4. Youth Race Which of the following race (s) best describe the youth? (Select all that apply)

African American	<input type="checkbox"/>	Guamanian/Chamorro	<input type="checkbox"/>	White	<input type="checkbox"/>
Alaska Native	<input type="checkbox"/>	Japanese	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>
American Indian	<input type="checkbox"/>	Korean	<input type="checkbox"/>	Other Pacific Islander	<input type="checkbox"/>
Asian Indian	<input type="checkbox"/>	Native Hawaiian	<input type="checkbox"/>	Declined (Don't ask again)	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Samoan	<input type="checkbox"/>	Unavailable/unknown	<input type="checkbox"/>
Filipino	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>		

5. Gender Identity

What sex was the youth assigned on their original birth certificate? _____

Youth's Current Gender Identity (Select all that apply):

Girl/Woman	<input type="checkbox"/>	Transgender Girl/Woman	<input type="checkbox"/>	Something else (e.g. non-binary, genderqueer, gender fluid)	<input type="checkbox"/>
Boy/Man	<input type="checkbox"/>	Transgender Boy/Man	<input type="checkbox"/>	Choose not to disclose	<input type="checkbox"/>

6. Youth Sexual Orientation

Do you think of yourself as (select from options below):

Bisexual Gay or Lesbian Straight Don't know

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Something else (e.g., queer, pansexual, asexual)

Please Specify: _____

7. Caregiver Information

Primary Caregiver/Guardian:		Preferred Method of Contact:	
Street address:			
City, State, Zip Code:			
Email Address:		Phone Number:	
Preferred Spoken Language:		Interpreter/translator needed:	

Relationship to youth: birth parent step parent adoptive parent foster parent grandparent sibling

other relative non-relative not previously listed prefer not to answer

Secondary Caregiver/Guardian:		Preferred Method of Contact:	
Street address:			
City, State, Zip Code:			
Email Address:		Phone Number:	
Preferred Spoken Language:		Interpreter/translator needed:	

Relationship to youth: birth parent step parent adoptive parent foster parent grandparent sibling

other relative non-relative not previously listed prefer not to answer

Who is the guardian of the child at the time of this referral? _____

If child is in out of home care, who would be the best contact for information about this youth? If the youth is in Residential Treatment please identify the person the assessor should speak with at the program to provide information about the youth and to coordinate contact with the youth i.e. Family Worker, Permanency Worker, clinical or other.

Name: _____ Role: _____

Contact Number: _____ Email Address: _____

8. Collaterals: Supports that know the child/youth well, add more if needed. Please specifically identify relationship to youth if applicable ie. CASA, Care Coordinator/Clinicians/Therapist/Case Managers, Educators, Respite/Kinship, Area Agencies etc.

Name: _____ Contact (Phone): _____

School District: _____ Contact (Email): _____

Name: _____ Contact (Phone): _____

Relationship: _____ Contact (Email): _____

Name: _____ Contact (Phone): _____

Relationship: _____ Contact (Email): _____

Name: _____ Contact (Phone): _____

Relationship: _____ Contact (Email): _____

9. Youth's Location at Time of Referral (Check all that apply)

Home	<input type="checkbox"/>	Foster Care (non- relative)	<input type="checkbox"/>	Residential Treatment	<input type="checkbox"/>
Guardianship	<input type="checkbox"/>	Psychiatric/Hospitalization	<input type="checkbox"/>	Other (specify below)	<input type="checkbox"/>
Relative Caregiver	<input type="checkbox"/>	Detention	<input type="checkbox"/>		

This current placement is the one under consideration for the CAT YES or No

Current Placement Name: _____ LOC of Program: _____ Admission Date: _____

Anticipated Location for the Assessment: _____

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10. Out of Home Care History: Including but not limited to foster care, relatives, residential, hospital, detention, etc. Please use comments for additional information or attach up-to-date placement history.

Name/Type of Placement	Reason for Placement	Date(s)

11. Hospital Visits	
In the past 12 months, how many times has the youth been hospitalized for psychiatric reasons?	
In the past 12 months, how many youth emergency room visits for psychiatric reasons or Rapid Response?	

12. Prior services/supports that the child/family has utilized in the past? *What kinds of services have the youth or their family received?* (Check all that apply)

Individual therapy <input type="checkbox"/>	Family therapy <input type="checkbox"/>	Group therapy <input type="checkbox"/>
Type of Therapy approach: _____	Respite, in or out-of-home <input type="checkbox"/>	
Psychiatric services <input type="checkbox"/>	On-call crisis services <input type="checkbox"/>	Independent Living Services <input type="checkbox"/>
Youth/Family case management <input type="checkbox"/>	Intensive In-Home Services <input type="checkbox"/>	Partial hospitalization <input type="checkbox"/>
School-based behavioral supports <input type="checkbox"/>	Substance misuse treatment <input type="checkbox"/>	Early Intervention Services <input type="checkbox"/>

13. Reason for Referral: What kinds of difficulties is the youth experiencing? (Check all that apply)

<input type="checkbox"/> History of Trauma/Traumatic Events/Victimization	<input type="checkbox"/> Psychotic behaviors
<input type="checkbox"/> Psychological Abuse	<input type="checkbox"/> Conduct/delinquency
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Intellectual disabilities/ Specific developmental disabilities
<input type="checkbox"/> Neglect	<input type="checkbox"/> Human Trafficking
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Depression
<input type="checkbox"/> Concentration (Decreased or Increased/Excessive)	<input type="checkbox"/> Anxiety
<input type="checkbox"/> School/educational performance	<input type="checkbox"/> Substance misuse, abuse, drug dependency
<input type="checkbox"/> Adjustment-related issues	<input type="checkbox"/> Disordered Eating (Diagnosed eating disorder)
<input type="checkbox"/> Mood changes/challenges	<input type="checkbox"/> Sleeping problems (Difficulty falling asleep/waking up)
<input type="checkbox"/> Suicide-related thoughts/actions	<input type="checkbox"/> Excluded from preschool or childcare due to challenges
<input type="checkbox"/> Self-injury/Self Harm	<input type="checkbox"/> Attachment and Separation problems

Current psychiatric diagnosis, if applicable: _____

Historical psychiatric diagnosis, if applicable: _____

Please describe this youth, including their strengths and challenges. Briefly describe the issues/problems which led to your decision to seek this assessment. Include length of time that this has been a challenge and the degree of impact, including behavioral challenges. Include family dynamics and description of checklist items above that can be captured in narrative. *Please note that the Assessor will request information and documentation relevant to the assessment*

Next Steps
DCYF /CME Save and send securely to NHCAT NHCAT@maximus.com
Community Referrals Save and send securely to DHHS: CAT Referral CATReferral@dhhs.nh.gov