COMPREHENSIVE ASSESSMENT FOR TREATMENT (CAT) Referral Form

1. Case information

Referring Agency: _____ Referral Date: _____

Referent Name: _____ Referent Phone: _____

Referent Email: _____ Approving Supervisor's Name: _____

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	☐	Mexican or Chicano	☐	Other Hispanic	☐
Cuban	☐	Puerto Rican	☐	Declined (don't ask again)	☐
Dominican	☐	South American	☐	Unavailable/unknown	☐

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

African American	☐	Guamanian/Chamorro	☐	White	☐
Alaska Native	☐	Japanese	☐	Other Asian	☐
American Indian	☐	Korean	☐	Other Pacific Islander	☐
Asian Indian	☐	Native Hawaiian	☐	Declined (Don't ask again)	☐
Chinese	☐	Samoan	☐	Unavailable/unknown	☐
Filipino	☐	Vietnamese	☐		

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	☐	Transgender Girl/Woman	☐	Something else (e.g. non-binary, genderqueer, gender fluid)	☐
Boy/Man	☐	Transgender Boy/Man	☐	Choose not to disclose	☐

6. Youth Sexual Orientation

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

Bisexual ☐ Gay or Lesbian ☐ Straight ☐ Don't know ☐

Something else (e.g., queer, pansexual, asexual) ☐ Please Specify: _____

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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?

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 *i.e. 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	☐	Foster Care (non- relative)	☐	Residential Treatment	☐
Guardianship	☐	Psychiatric/Hospitalization	☐	Other (specify below)	☐
Relative Caregiver	☐	Detention	☐		
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	☐	Family therapy	☐	Group therapy	☐
Type of Therapy approach: _____				Respite, in or out-of-home	☐
Psychiatric services	☐	On-call crisis services	☐	Independent Living Services	☐
Youth/Family case management	☐	Intensive In-Home Services	☐	Partial hospitalization	☐
School-based behavioral supports	☐	Substance misuse treatment	☐	Early Intervention Services	☐

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

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

Current psychiatric diagnosis, if applicable: _____

Historical psychiatric diagnosis, if applicable: _____

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