Healing Hoofbeats, LLC

Referral Form for Supervised Visitation

Please Fax or Email this form to the appropriate communication below

Date: _____

Client Name: _____DOB: _____ Age: _____
Gender: _____ Culture/Ethnicity: _____
Address: _____
Phone Number: _____
Caregiver: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Name of DCF worker: _____ Title: _____
DCF worker Email: _____ Phone: _____
Referral Source & Name: _____ Phone: _____
Is this court ordered? Y N

Significant Family Members involved in treatment or visitations:

_____
_____

Presenting Problem (include background on parent and child/youth):

_____
_____
_____
_____

Suicidal/Homicidal/Aggressive/Risky behaviors of concern:

_____
_____
_____

Services Requesting (circle one & explain desired outcomes for the family): Observational Supportive

_____
_____
_____
_____

Restrictions to Visitations (ie, phone calls, photographs, activities, questioning style, conversation topics, etc)

_____
_____

Previous Mental Health Provider(s): _____

Would you be interested in our Parenting Support Groups? Yes No

P: (860) 459-4115 F: (860) 733-0323 E: HealingHoofbeatsLLC@gmail.com