Creative Potential, LLC
1031 Norwich New London Tpk.
Unit 10 Uncasville, CT. 06382
p-(860)848-0514, f-(860)-848-0523
www.Creativepotentialllc.com

Referral Form

Important Info

Creative Potential provides credentialed and non-credentialed services for DCF.

Non-credentialed services include Parent Support which follows the model of TSS to enhance parenting skills, self-awareness, advocacy, and domestic stability. DCF frequently uses this service in conjunction with TSS to enhance outcomes. Life coaching which is mentorship for adults is also available. TSS is therapeutic mentoring.

Additionally, Creative Potential provides in-home and community-based (ABA) Behavioral Services for children and families. We provide a BCBA/ LCSW and behavior technicians for Beacon Health Options' ASD program and for DCF when requested.

Please fill out a referral for each individual service and child requested. Once complete, email the document(s) to INFO@CREATIVEPOTENTIALLLC.COM

Thank You!

Today's Date:		Area Office:			
SW name:		SW email address:		SW phone:	C: O:
SW supervisor:		Supervisor Email Address:		Supervisor phone:	

Childs Name:		Case ID:		Child ID:	
Case Name:		Case Type:	**SS SV TSS LCSW TC LIST PS Mentor OTHER: __________**	Hours Per wk.:	
DOB:		Guardian Name:		Guardian relationship:	
Address:					
Guardian Contact Information:	Phone: Email:				
Other Needed information:					

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Please provide us with information about the client's domestic arrangements to support effective and timely communication regarding visits (For example, child resides with mother and grandmother Tuesday through Thursday and visits with Father and stepmother Friday through Monday):

Please provide names of other approved relationships to child(ren), addresses, phone numbers, and email addresses for all parties listed above:

Please list all known service providers, agencies, and institutions (including schools) also working with client (name, affiliation, #, email address):

Please provide us with any recent case reviews, treatment plans, and/or assessments that will enhance our understanding of client's current cognitive, social, emotional, and behavioral functioning across contexts. If necessary, you can send them to us via mail or email them as attachments. Faxing is also available.

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Please take a moment to consider the client's current level of functioning and identify some specific goals for treatment and identify a means of assessing improvement that providers can use to establish success, keeping in mind that we can't "make" anyone change. What are the primary objectives of services (if appropriate, please use LIST system)?

1.

2.

3.

Please use the space below (and additional pages, if necessary) to share any additional information that you feel will help us serve this client more effectively:

*** ATTENTION *** Supervised Visits:

Number of Children Attending:		**Car seat Requirements:**	**Booster, 5 point, Infant, ETC**		
Visit Length:		**Transportation Time:**		**Mileage:**	**Yes or No**
Who is Transported:	**Parent:**		**Child:**		**Both:**
Address of pick up:					
Address of visit:					
	If at DCF office how many visits required before allowing to be in community setting: ______				
Address of Drop Off:					
Other Parties Allowed to attend:	If the name is not listed the person will not be allowed to attend without prior authorization from SW.				
Safety or Other Concerns:					

**** Please include any Group rates in funding authorization****