



**POSITIVE ADVERSITY YOUTH SERVICES INC.**  
***SUPERVISED VISITATION***  
***REFERRAL FORM***

*Please download and print this form. Complete it and email it to Positive Adversity Youth Services using the contact information listed at the bottom of the form.*

Date of Referral: \_\_\_\_\_ Child Car Safety Seat Needed? Yes No

Child/Youth Name: \_\_\_\_\_ Transportation: Yes No

Date of Birth: \_\_\_\_\_ The child/youth is: Male Female

Full Address: \_\_\_\_\_  
Street City/Town State Zip

**Family Information:**

Parent / Caregiver's Name: \_\_\_\_\_ Relationship to child/youth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary language of child/family: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Is family / guardian aware and in agreement with referral? Yes No

Has family been informed about what the service offers? Yes No

**Mental Health Diagnosis:**

Primary: \_\_\_\_\_ DSM V/ICD10 Code: \_\_\_\_\_

Secondary: \_\_\_\_\_ DSM V/ICD10 Code: \_\_\_\_\_

What is allowed and what isn't allowed during the visit? (Be specific and as detailed as possible):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for Referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the youth involved with Department of Children & Families (DCF) or Department of Social Services (DSS) or Court Support Service Division (CSSD) or Department of Developmental Services (DDS)? Yes No

If yes, please list the name and contact information for the DCF/DSS/CSSD/DDS caseworker(s) and briefly describe the reason for involvement:

\_\_\_\_\_  
\_\_\_\_\_

Is the youth currently being treated for an active medical diagnosis? Yes No

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please include with this referral:

- \_\_\_\_\_ Copy of release of information from referral source
- \_\_\_\_\_ Copy of Care Plan or Treatment Plan

Referred by: (check one)

- \_\_\_ Case Worker    \_\_\_ In-Home Therapist    \_\_\_ Outpatient Therapist    \_\_\_ Other

Agency: \_\_\_\_\_

Name of person referring: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Number of Hours Approved \_\_\_\_\_

**Positive Adversity Youth Services INC.**

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New London, CT 06320

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**Email:** PositiveAdversity@gmail.com

