MISTER HEALTH

The CONNECT Program™

IN-HOME & VIRTUAL FAMILY THERAPY

Relationship-centered support for the entire family system

Complete this fillable form to request in-home or virtual individual and family counseling. Families are matched with a licensed clinician who uses the CONNECT Model™. Services continue based on clinical need and treatment goals; insurance eligibility and benefits are verified before scheduling.

1 REFERRAL OVERVIEW

Referral date | **Person completing this form** | **Organization / agency (if applicable)** | **Relationship to client/family**

Phone | **Email** | **Best days/times to reach the family**

Referral source type

- ☐ Self / family
- ☐ School
- ☐ Court / probation
- ☐ Other
- ☐ Healthcare provider
- ☐ DCF / child welfare
- ☐ Community agency

Requested service format

- ☐ In-home
- ☐ Virtual
- ☐ Either / no preference

Preferred contact

- ☐ Phone
- ☐ Email
- ☐ Text

Priority

- ☐ Routine
- ☐ Time-sensitive

2 PRIMARY CLIENT INFORMATION

Legal name | **Preferred name** | **Date of birth** | **Age**

Pronouns (optional) | **Primary language** | **School / employer (optional)**

Street address | **City** | **State** | **ZIP**

Phone | **Email**

Client is under age 18

- ☐ Yes
- ☐ No

3 PARENT / GUARDIAN AND INSURANCE INFORMATION

Parent / guardian name | **Relationship** | **Phone** | **Email**

Primary insurance plan | **Member ID** | **Subscriber name**

Subscriber date of birth | **Relationship to client** | **Medicaid / HUSKY ID (if applicable)**

Insurance card

- ☐ Uploaded
- ☐ Will provide

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4 FAMILY MEMBERS AND HOUSEHOLD

List people who live in the home and/or may participate in treatment. Add a separate page if more space is needed.

Name	DOB / age	Relationship	Lives in home?	Expected to participate?

Custody, visitation, guardianship, household, or legal considerations relevant to treatment

5 REASON FOR REFERRAL

- ☐ Family conflict / communication
- ☐ Anxiety / panic
- ☐ Depression / low mood
- ☐ Anger / emotional regulation
- ☐ ADHD / executive functioning
- ☐ Trauma / PTSD
- ☐ Grief / loss
- ☐ School refusal / academics
- ☐ Behavioral concerns
- ☐ Parenting / caregiver stress
- ☐ Divorce / separation / blended family
- ☐ Sibling conflict
- ☐ Social / peer difficulties
- ☐ Substance use concerns
- ☐ LGBTQ+ / identity support
- ☐ Young adult independence
- ☐ Housing / community stressors
- ☐ Other

Please describe what is happening now and what led to this referral

6 GOALS, STRENGTHS, AND PREFERENCES

What would the family like to be different?

Strengths, protective factors, and supports

Clinician preferences, cultural considerations, language needs, accessibility needs, or accommodations

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7 CURRENT TREATMENT AND CARE COORDINATION

Current diagnoses (if known)

Current medications (if known)

Current therapists, prescribers, medical providers, case managers, or programs

Prior therapy, emergency visits, hospitalizations, or higher levels of care

Systems currently involved

- School
- Court / probation
- Psychiatry
- Other
- DCF / child welfare
- Primary care / pediatrics
- Case management

8 AUTHORIZATION AND SUBMISSION

By typing my name below, I confirm that this information is accurate to the best of my knowledge, that I am authorized to submit it, and that MisterHealth may contact the client or family regarding this referral. Referral does not guarantee admission, appointment availability, or insurance coverage.

☐ I have read and agree to the statement above.

Typed name / signature

Date

Relationship / title

Please email referral form to Connect@MisterHealth.com or fax it to (860) 920-7320