

# Tree of Life Behavioral Health Services, LLC

## Supervised Visitation Program Referral Form

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### Referral Information

Date of Referral: \_\_\_\_\_  
Person Completing Referral: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relationship to Family/Case: \_\_\_\_\_

Referral Source/Agency: \_\_\_\_\_  
Title/Role: \_\_\_\_\_  
Email: \_\_\_\_\_  
Preferred Contact:  Phone  Email  Text  Other  
\_\_\_\_\_

### Service Requested

Supervised Visitation  
 Intake/Assessment  
 Other: \_\_\_\_\_

Monitored Exchange  
 Visit Documentation/Observation Notes

Reason for Referral:

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

Requested Start Date: \_\_\_\_\_  
Preferred Days/Times: \_\_\_\_\_

Frequency:  Weekly  Biweekly  Monthly  As ordered  
 Other \_\_\_\_\_  
Length of Visits:  1 hour  2 hours  Other \_\_\_\_\_

### Child/Children Information

#### Child 1

Name: \_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ School/Program, if applicable: \_\_\_\_\_  
Medical, developmental, behavioral, emotional, or safety concerns:

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

#### Child 2

Name: \_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ School/Program, if applicable: \_\_\_\_\_  
Medical, developmental, behavioral, emotional, or safety concerns:

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

### Visiting Parent/Participant Information

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Primary Language: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Email: \_\_\_\_\_  
Relationship to Child/Children: \_\_\_\_\_  
Interpreter Needed:  Yes  No Language: \_\_\_\_\_

Known safety, behavioral, mental health, substance use, or court-related concerns:

\_\_\_\_\_

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## Custodial Parent/Guardian Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship to Child/Children: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Interpreter Needed:  Yes  No Language: \_\_\_\_\_  
Concerns, preferences, or information important for safe service planning:

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## Legal/Court Information

Court Order Related to Visitation:  Yes  No  Pending  Unknown Court Name: \_\_\_\_\_  
Docket/Case Number: \_\_\_\_\_ DCF/Social Worker: \_\_\_\_\_  
Attorney for Visiting Parent: \_\_\_\_\_ Attorney Phone/Email: \_\_\_\_\_  
Attorney for Custodial Parent/Guardian: \_\_\_\_\_ Attorney Phone/Email: \_\_\_\_\_  
Restraining orders, no-contact orders, safety plans, or other legal restrictions:  Yes  No  Unknown

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## Safety and Risk Information

Domestic violence concerns  Substance use concerns  
 Mental health concerns  History of threats/aggression  
 Child abuse or neglect concerns  Abduction risk  
 Weapons-related concerns  Active restraining/no-contact order  
 High-conflict co-parenting  Other: \_\_\_\_\_  
Details regarding checked items:

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Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Phone: \_\_\_\_\_

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## Visit Planning Information

Specific visit guidelines, rules, or restrictions:

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Are visits allowed to include gifts, food, photos, phone use, or outside activities?

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Documentation/Reporting Requested:  Yes  No Recipient/Frequency: \_\_\_\_\_

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## Payment for Service

Responsible Party for Payment: \_\_\_\_\_ Payment Contact Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Payment Arrangement:  Self-pay  Agency-paid  Court-

ordered party responsible  Other \_\_\_\_\_

Additional payment notes:

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### Required Attachments, If Available

- |  |   |
|--|---|
| <input type="checkbox"/> Court order/visitation order            | <input type="checkbox"/> Restraining order/no-contact order                   |
| <input type="checkbox"/> Safety plan                             | <input type="checkbox"/> Custody/guardianship documentation                   |
| <input type="checkbox"/> Referral letter or agency documentation | <input type="checkbox"/> Relevant clinical, behavioral, or safety information |
| <input type="checkbox"/> Other: _____                            |   |

### Referral Authorization and Consent

By signing below, I confirm that the information provided is accurate to the best of my knowledge and that I am authorized to submit this referral. I understand that completion of this referral form does not guarantee acceptance into services and that Tree of Life Behavioral Health Services, LLC may require additional intake information, documentation, and service planning before visits begin.

Name of Person Completing Form: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Office Use Only

Date Received: \_\_\_\_\_

Received By: \_\_\_\_\_

Referral Status:  Accepted  Pending  Declined  More information needed

Intake Scheduled:  Yes  No Date/Time:

\_\_\_\_\_

Notes:

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*Services are provided in accordance with applicable guidelines, referrals, safety considerations, and family needs.*