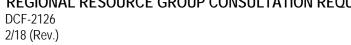
State of Connecticut Department of Children and Families REGIONAL RESOURCE GROUP CONSULTATION REQUEST





DCF Office:		(or) Regional Uni	(or) Regional Unit:		Assigned to:	
Name of Person Making Referral:		Phone:	Phone:		Date:	
Case Type:						
Adolescent FAR	☐ FAS	SU \square	Intake	☐ Ju	venile Services	
Ongoing Services Permanency Probate			☐ Special Investigations Unit ☐ Voluntary Services			
Reason for Consultation: (check the ONE box that applies)						
☐ There is an emergency we have become aware of in the last 24 hours.						
☐ The child is in the hospital (inpatient) and is in need of discharge planning.						
☐ Case needs to be reviewed for treatment recommendations due to mental health, substance use, intimate partner violence, education or medical issues.						
☐ We are updating the RRG on issues from a prior consultation.						
(check all that apply) — — — —			☐ Mental Health	Nursing	☐ Substance Use	
Case Name:	Date Case Opened:	DCF Legal Status:			LINK #:	
Child's Name:	DOB:	Race:	Ethnicity	y:	Gender:	
Is Child in Placement? Yes No	If Yes, where?:					
What are the questions for the RRG?						
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Brief History: (relevant to the type of consult and questions above)						
Has the RRG been previously involved in this case? Yes No. If Yes, who and when?						
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