# Birth Support, Education & Beyond, LLC

## DCF WAF Referral for Perinatal Support Service (PSS)

### DCF Staff Contact Information:

**Todays Date:** ____________ **DCF Office & Region:** ____________

| | Name | Phone | Email |
|---|---|---|---|
| **DCF Social Worker** | | | |
| **DCF Supervising Social Worker** | | | |
| **After Hours Emergency Contact:** | | | |
| **Other Collaborating Service Providers** (clinician, treatment provider, specialists, etc.) | | | |

### Client Information:

**Client Name:** ____________ **DOB:** ____________ **Age:** ____________

**Client Phone Number:** ____________ **Client Email:** ____________

**Street Address:** ____________ **City:** ____________ **Zip Code:** ____________

**Client Resides with?** ____________

**Pregnant?** ☐ **yes** ☐ **no** **Estimated Due Date:** ____________

**First Baby?** ☐ **yes** ☐ **no** **Parenting?** ☐ **yes** ☐ **no**

**Child(ren):**

**1. Name:** ____________ **DOB:** ____________

**2. Name:** ____________ **DOB:** ____________

**Conservator & Contact Information (if applicable):** ____________

### Background & Clinical Information:

Current Mental Health Diagnosis & ICD Code(s):

**Specific Goals/Concerns/History** (trauma history, domestic violence, family concerns, relationship issues, developmental history, learning style, etc. that may help us serve the client better?)

**Please send WAF approval and completed referral for services via secured email to: traci.mccomiskey@bsebct.org. Thank you**

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