# Multisystemic Therapy (MST)

# Referral Form

REFERRAL DATE: REQUESTED START: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **YOUTH:** \_\_\_\_ \_\_  **AGE:** \_\_\_\_\_\_ **DOB:** \_\_\_ \_\_\_

GENDER: \_\_\_\_\_\_ RACE/ ETHNICITY: Select Language Spoken in the Home: \_\_\_\_\_\_

RESIDES WITH: RELATIONSHIP TO YOUTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian? \_\_\_\_\_\_\_

CELL # \_\_\_\_\_\_\_\_\_\_\_\_ HOME # \_\_\_\_\_\_\_\_\_\_\_ WORK # \_\_\_\_\_\_\_\_\_\_\_\_ OK TO CALL WORK? \_\_\_\_\_\_

CURRENT PHYSICAL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHERS IN THE HOME AND RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS THE REFERRAL BEEN DISCUSSED WITH THE FAMILY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THEIR RESPONSE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MST Criteria** Please check all that apply:

|  |
| --- |
|[ ]  The Youth is currently between the ages of 11 and 17 years. |
|[ ]  The Youth is living at home a permanent caregiver. |
|  | **If yes**, will the youth return home in the next 30 days? Choose an item. |
|[ ]  The Youth is **not** actively suicidal, homicidal, or psychotic. |
|[ ]  The Youth has Autism Spectrum Disorder or other pervasive developmental delays.  Note: Youth with severe are not appropriate MST services. |
|[ ]  The Youth’s referral behaviors are not **primarily** related to sexual offending. |
| [ ]  | The Youth is **not** receiving intensive in-home or intensive outpatient services from another provider that are expected to continue for the duration of MST treatment.  |

**Youth Specific Behaviors:** Check ALL criteria that are relevant to the Youth being referred.

|  |  |  |  |
| --- | --- | --- | --- |
| Past 3 Months | Past Year | Behavior Type | Describe: Frequency/Intensity/location |
|[ ] [ ]  **At risk of out-of-home placement** | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Involvement with the legal system | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Physical Aggression | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Substance Abuse/Use | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Theft | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Verbal Aggression | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Property Destruction/Vandalism | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Runaway | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  School Failure/ Truancy | \_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  School Suspensions/ Expulsions | \_\_\_\_\_\_\_\_\_\_\_ |

### Provide additional information regarding youth’s **CURRENT** EXTERNALIZING behaviors:

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

# **Youth Background**

OTHER PRIOR SERVICES:

CURRENT SERVICES: \_\_\_\_\_

**Agency involvement:**  *Select and describe all historical or current agency involvement, including contact information of current staff assigned.*

Select CPS \_\_\_\_\_\_\_\_\_\_\_\_

Select DSS \_\_\_\_\_\_\_\_\_\_\_\_

Select CSB \_\_\_\_\_\_\_\_\_\_\_\_

Select CSU \_\_\_\_\_\_\_\_\_\_\_\_

Select SPED \_\_\_\_\_\_\_\_\_\_\_\_ IEP: \_\_\_\_\_\_

###  **CSA Details**

YOUTH OPEN TO CSA: \_\_\_\_\_\_\_\_\_\_\_ YOUTH MANDATE: Select

CSA CASEMANAGER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_

DATE FAPT REQUESTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE CPMT APPROVED: \_\_\_\_\_\_\_\_\_\_\_\_\_

NEXT FAPT DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIME: LOCATION: \_\_\_\_\_\_\_\_\_\_\_

### **Attach all requested information:**

For more information about MST treatment or referral process, refer to the Goals and Guidelines, located at [www.ebanetwork.com](http://www.ebanetwork.com)

For case specific questions, please contact the local MST Supervisor.

[ ]  Release of information/ Consent

[ ]  FACE SHEET

[ ]  FAPT approved IFSP and meeting notes

[ ]  Most Recent CANS

[ ]  CHINS Approval/ Court order (as applicable)

[ ]  Recent assessments/ treatment reports (as applicable)

**E-mail referral form and packet the EBA Regional Service Coordinator:**

Shenandoah Valley: RSCnorth@ebanetwork.com

Staunton/ Charlottesville: RSCcentral@ebanetwork.com

Roanoke and Martinsville: RSCwest@ebanetwork.com