# NCG Functional Family Therapy (FFT) Referral Form

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

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

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

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

CELL # HOME # \_\_\_\_\_\_\_\_ WORK # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUTH’S CURRENT PHYSICAL ADDRESS:

CITY: ZIP: \_\_\_\_

OTHERS IN THE HOME AND RELATIONSHIP:

REFERRAL HAS BEEN DISCUSSED WITH THE FAMILY? Choose an item.

Is the family willing and able to engage in FFT? Select Yes or no THEIR RESPONSE?\_\_\_\_\_\_\_\_\_\_

Youth Specifics Please select True or False for the following statements:

|  |  |
| --- | --- |
| select one | The Youth is living in the community or is ready to return to home within the next 30 days. |
| select one | Youth has severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.  *Note: youth on the higher end of the autism spectrum may be served.* |
| select one | Youth needs sexual offender treatment as a primary need.  *Note: FFT may work with families that that have begun or completed treatment with a CSOTP or youth who’s sexualized behaviors is secondary to other externalizing behaviors.* |
| select one | The family is not receiving any other form of family therapy or parent coaching services from another provider that are expected to continue for the duration of FFT treatment. |

Background

PRIOR SERVICES:

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

Other agency involvement: *Select and describe all historical or current agency involvement.*

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

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

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

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

Select SPED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IEP: Click or tap to enter a date.

**FFT Priority Criteria Checklist**

Check ALL criteria that are relevant to the Youth being referred.

|  |  |  |  |
| --- | --- | --- | --- |
| Past 3 Months | Past Year | Criteria | Describe Frequency/Intensity/location  (i.e. daily, 1 time, weekly/ at home, community etc.) |
|  |  | **At risk of out-of-home placement** |  |
|  |  | Physical Aggression |  |
|  |  | Substance Abuse/Use |  |
|  |  | Negative Peer Associations |  |
|  |  | Theft |  |
|  |  | Verbal Aggression |  |
|  |  | Property Destruction/Vandalism |  |
|  |  | Runaway |  |
|  |  | Truancy |  |
|  |  | School Failure/ Suspensions |  |
|  |  | Family Conflict/ Discord |  |

Briefly, provide additional information regarding youth’s **CURRENT** EXTERNALIZING behaviors that put him/her at risk for out-of-home placement:

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

CSA Details

CSA FIPS Code: YOUTH OPEN TO CSA: \_\_\_\_\_\_\_\_\_\_\_ MANDATE: Choose an item.

REFERRAL AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

FAPT REQUESTED DATE: \_\_\_\_\_\_\_\_\_

CPMT APPROVED DATE: \_\_\_\_\_\_\_\_\_\_\_

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

Attach all requested information for a new referral:

Release of information

FACE SHEET

POSO or Funding Approval

FAPT approved Service Plan and meeting notes

Recent CANS

Recent assessments or evaluations

**E-mail referral packet to** [**RSCNorth@ebanetwork.com**](mailto:RSCNorth@ebanetwork.com)

**Referrals may also be called into the NCG Call Center: *1-877-566-9624.***

To staff a case with the local FFT Supervisor, please contact:

Kendall McCarthy, LPC, FFT Supervisor, Site Director   
**(d)** 571.364.7386 |  **(o)** 703.257.5997   
[kendall.mccarthy@NCGcommunity.com](mailto:kendall.mccarthy@NCGcommunity.com)