# 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? yes or no

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

YOUTH’S CURRENT PHYSICAL ADDRESS:

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

OTHERS IN THE HOME AND RELATIONSHIP:

* Youth has siblings (or other household members) that display inclusionary behaviors, regardless of system involvement.

REFERRAL HAS BEEN DISCUSSED WITH THE FAMILY? select

Is the family willing and able to engage in FFT? Select THEIR RESPONSE?\_\_\_\_\_\_\_\_\_\_

Other Services to the Family: Describe current and historical provider and agency involvement.

PRIOR SERVICES:

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

No access to other services (either due to insurance barriers, provider limitations, or transportation barriers)

Current or prior services were unsuccessful in creating lasting change or meeting the family’s need.

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.

☐ Youth is receiving sexual offender treatment. *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.*

Other Agency Involvement:

|  |  |  |
| --- | --- | --- |
| Select | Local Agency | Details or Contact information |
| Select | CPS |  |
| Select | DSS |  |
| Select | CSB |  |
| Select | CSU | **Probation Status:** Click or tap here to enter text. |
| Select | SPED | IEP: Click or tap to enter a date. |

Youth is involved in numerous local systems (i.e. prevention, CPS, School SPED, CSU)

### Youth Specifics

|  |  |  |
| --- | --- | --- |
| *Check ALL that apply* | | **Describe Frequency/Intensity/location****(i.e. daily, 1 time, weekly/ at home, community etc.)** |
|  | Youth returning to community from out-of-home placement within the next 30 days (i.e., direct care, detention, group home, residential) | *Describe, youth transitioning from, timeframe, etc.* |
|  | Youth at risk of out-of-home placement | Click or tap here to enter text. |
|  | Youth has severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism (exclusionary criteria). | *Note: youth on the higher end of the autism spectrum may be served*. |

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

### Briefly provide additional information regarding youth’s **CURRENT** EXTERNALIZING behaviors or reason for refferal:

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

### REFERRAL Agency:

Locality: \_\_\_\_\_\_\_\_\_\_\_\_\_ OPEN TO CSA: \_\_\_\_\_\_\_\_\_\_\_ MANDATE: Choose

ASSIGNED CASEMANAGER: \_\_\_\_\_\_\_\_\_\_ AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

**FORM COMPLETED BY:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_.

Attach all requested information for an FFT referral: Send referrals to [referral@ncgcare.com](mailto:referral@ncgcare.com)

FACE SHEET

Purchase order or Funding Approval

FAPT approved Service Plan and meeting notes

Recent CANS/ YASI

Recent assessments or evaluations

Release of information