# UMFS Functional Family Therapy (FFT) Referral Form

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

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

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

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

CELL # Other # \_\_\_\_\_\_\_\_

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? Choose an item.

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

Other Services to the Family: Select and describe all historical or current 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 youth that have begun or completed treatment with a CSOTP or youth who’s sexualized behaviors is secondary to other externalizing behaviors.*

### Youth Specifics and FFT Priority

|  |  |
| --- | --- |
| *Check ALL that Apply* | **Explain** |
|[ ]  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. | *Note: youth on the higher end of the autism spectrum may be served*. |
| Specific BehaviorsCheck all that apply | Past 3 Months | Past Year | **Briefly** 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 any additional information regarding youth’s **CURRENT** EXTERNALIZING behaviors or reason for referral:

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

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.

Referral Agency:

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

[ ]  FAPT REQUESTED: \_\_\_\_\_\_\_\_\_ [ ]  CPMT APPROVED: \_\_\_\_\_\_\_\_\_\_\_

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

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

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

### Attach the requested information for a new referral.

[ ]  Release of information

[ ]  FACE SHEET

[ ]  POSO or Funding Approval (if available)

[ ]  FAPT approved Service Plan and meeting notes

[ ]  Recent CANS

[ ]  Recent assessments or evaluations



**Email the Referral Packet to** RSCcentral@ebanetwork.com

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

Sarah Hess, FFT Program Manager
**(d)**  804.248.1059 |  **(o)** **540.898.1773  x 304**
e-mail: shess@umfs.org