# 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](mailto: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**](tel:540.898.1773%20x304)   
e-mail: [shess@umfs.org](mailto:shess@umfs.org)