 Functional Family Therapy Referral Form

*Please complete as many sections as possible. \*Please note required sections.*

|  |  |
| --- | --- |
| **Date of Referral:** |  |
| Basic Screening Questions:1. Is there a youth residing in the home between the ages of 11 and 17 years old?
2. Is there a pattern of delinquent behavior for this youth?
3. Is there an adult caregiver in the home that is committed and willing to participate in therapy with the youth?
 |
| **Youth’s Information** |
| \*Name of Youth: |  |
| \*Street Address: |  | \*City |  | State |  | Zip |  |
| \*Youth’s Phone Number:  |  |
| \*Youth’s Date of Birth (or age): |  |
| Gender of Youth: |[ ]  Female |[ ]  Male |
| Ethnicity of Youth: |[ ]  African American |[ ]  Hispanic |[ ]  Samoan |[ ]  Caucasian |[ ]  Asian |
|  |[ ]  Biracial |[ ]  Alaskan Native |[ ]  Maori |[ ]  Pacific Islander |[ ]  Other |
| Does the youth currently reside in a family setting, with the parent figure who will be participating in FFT? | [ ]  Yes | *If no* – is there a plan in place for the youth to transition to this family setting within 30 days? | [ ]  Yes |
|  | [ ]  No |  | [ ]  No |
| Is a translator needed for this youth and/or family? | [ ]  Yes | [ ]  No |
|  |
| **Parent/Guardian Information** |
| \*Name of Parent/Guardian: |  |
| \*Street Address: |  | \*City |  | State |  | Zip |  |
| \*Parent/Guardian’s Phone Number: |  |
| Parent/Guardian Marital Status: |[ ]  Married |[ ]  Single |[ ]  Divorced |[ ]  Widowed |[ ]  Separated |
|  |
| **Referral Information** |
| \*Reason for Referral: |[ ]  Referral for Delinquent Behavior |[ ]  Referral for youth/parent conflict |
|  |[ ]  Referral for Mental Health Issues |[ ]  Referral for Gang Involvement |
|  |[ ]  Referral for Family Reunification |[ ]  Referral for Runaway Behavior |
|  |[ ]  Family Transition Planning (return home) |[ ]  Referral for School/Truancy Behavior |
|  |[ ]  Referral for Family Substance Abuse/Use |[ ]  Other (please list):  |
| Summary of Reason for Referral (please include any safety concerns or potential for violence): |  |
| \*Referral Source: |[ ]  Police |[ ]  UNCOM – community center |
|  |[ ]  School |[ ]  Mental Health |
|  |[ ]  Self-Referral |[ ]  Child Welfare |
|  |[ ]  Juvenile Justice/Human ServicesWorker/Court personnel |[ ]  Other (please list): |
|  |  |  |
| \*Name of Person Making Referral: |  |
| \*Contact Information: |  |
| Referral Status: |[ ]  Mandatory |[ ]  Voluntary |[ ]  Unknown |
| Safety Concerns/Potential for Violence: |  |
| If Referral Source is Juvenile Justice | Juvenile ID Number |  |
|  | YASI Score | Risk: | Protective: |
|  |
| **\*Other Family Members** |
| Name: |  | Relationship: |  | Age: |  |
| Name: |  | Relationship: |  | Age: |  |
| Name: |  | Relationship: |  | Age: |  |
| Name: |  | Relationship: |  | Age: |  |
| Name: |  | Relationship: |  | Age: |  |
|  |
| **Family Availability:** |
|[ ]  Monday | Times: |  |
|[ ]  Tuesday | Times: |  |
|[ ]  Wednesday | Times: |  |
|[ ]  Thursday | Times: |  |
|[ ]  Friday | Times: |  |
|[ ]  Saturday | Times: |  |
|[ ]  Sunday | Times: |  |

Please send referral to:

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FFT Program Manager

Family Services Department



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