C3/C8 FFT Referral Form

Referrals will be sent back to the referring party if the referral is not completed in its entirety

Referral Date:	Date Received (for internal use):

County of Service:

☐ Alachua ☐ Baker ☐ Bradford ☐ Columbia ☐ Dixie ☐ Gilchrist
☐ Hamilton ☐ Lafayette ☐ Levy ☐ Putman ☐ Suwannee ☐ Union

Youth:

Name: ____________________________

Preferred Name: ____________________

Age: _________

Date of Birth: / /

Ethnicity: ______________________

Sex (Circle): Male Female Transgender

Preferred Pronouns (Circle):

He/Him She/Her They/Them

Diagnosis (Required): _______________

Guardian:

Name: ______________________________

Ethnicity: ___________________________

Relation to Youth: _________________________

Telephone Number: _______________________

Email Address: ____________________________

Service Preference:

Office Home

Additional Information:

Home Address: ____ Zip Code: _______________

Youth School: ____ Grade: __________________

Special Education (Y/N): _____________

If yes, please specify: ____

Medicaid/Insurance: ____

Referring Party:

Name/Title: ____

Organization: ____

Email/Telephone: ____

Has the family consented to services prior to submission of referral? (Y/N): __________________

Confidential Information

Referring Party:

Name/Title: ____

Organization: ____

Email/Telephone: ____

Has the family consented to services prior to submission of referral? (Y/N): ________________

Other Interested Parties:

Case Manager: ____ Email/Phone: __________________________

Juvenile Probation Officer: _______________________________ Email/Phone: __________________________

Child Protective Investigator: _____________________________ Email/Phone: __________________________

Other: ____ Email/Phone: __________________________

If referrals were made to other agencies/organizations/resources, please indicate:

Agency(s) (e.g. Child Protection, Community)	Professional (e.g. OT, Psychologist)
1. _________________________________	_____________________________________
2. _________________________________	_____________________________________
3. _________________________________	_____________________________________

FFT Criteria/Eligibility:

Refer to the FFT information sheet or contact the Site Director for questions regarding service eligibility

1. Does the youth have a formal caretaker/guardian? Yes ☐ No ☐

   If answered no, please explain:

2. Is the family currently receiving/participating in other services for behavioral health, mental health or and/or substance abuse? Yes ☐ No ☐

   If answered no, please explain:

3. Does the youth have a diagnosed or undiagnosed neurodevelopmental condition that would interfere with his/her ability to benefit from FFT? Yes ☐ No ☐

   If answered no, please explain:

4. Has the youth been classified as a sexual offender? Yes ☐ No ☐

   If answered yes, please explain, and indicate if the youth has attended psychosexual treatment:

Reason for Referral:
Please explain the dynamics of the family, behaviors exhibited by the youth, and any other pertinent information that should be known by the FFT clinician:
Delinquency History:
Please explain the youth's current involvement with the delinquency system to include history of offenses, YSL, and current delinquency status:

Documents Included with Referral Submission:

☐ DCF Documents

☐ School Records

☐ Mental Health Records/Evals

☐ Substance Abuse Evaluation

☐ Psychological/Psychiatric Evaluation

☐ Arrest Reports

☐ Other: _______________

Please email referral and all supporting documentation to: bfcgainesville@bayskids.org

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INTERNAL USE ONLY

Referral Status (Please Indicate):

Accepted ☐ Ineligible/Rejected ☐ Waitlist ☐

Referral Reviewed By: ____ Date: ___________________

Referral Assigned To: ____ Date: ___________________