Osceola Functional Family Therapy Referral Form

Referral Date:	Date Received (for internal use):

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

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 (Circle):

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

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

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

If answered no, please explain:

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

If answered yes, please explain:

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

If answered yes, please explain:

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

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

Reason for Referral:
Please explain the dynamics of the family, behaviours 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: bfc-osceola@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: __________