UCFS
United Community & Family Services

MULTIDIMENSIONAL FAMILY THERAPY REFERRAL FORM

I. CLIENT INFORMATION (Child/Adolescent)

Name: DOB:

Gender: Race:

Primary Language spoken in home:

Medical Insurance Plan Name: Plan ID#

II. REFERRAL INFORMATION

Referral Type:

Name: Date of Referral:

Agency: Address: Phone #:

Legal Status:

Court: Probation Officer:

Current / Recent Charges:

Past Charges:

Court Orders:

Date of Last Arrest:

DCF Involved: Yes ☐ No ☐ Status:

Social Worker Name: Phone #:

Area Office:

Family Link# Client Link#

III. REASON FOR REFERRAL

Describe reason for referral (current challenges, issues, concerns):

Current substance use (if yes, describe): Yes ☐ No ☐

Any known / suspected safety concerns in the home? (if yes, explain): Yes ☐ No ☐

Any weapons in the home? Yes ☐ No ☐ (if yes, explain):

Supporting documentation sent to MDFT (e.g. Evaluations, etc.):

IV. BACKGROUND INFORMATION

Does child live with parent(s)? Yes ☐ No ☐ *If No, please identify the adult responsible for the child's care:*

Name: Relationship:

Address: Phone:

PARENTS:

Mother's Name: Legal Guardian: Yes ☐ No ☐

Address: Phone:

Father's Name: Legal Guardian: Yes ☐ No ☐

Address: Phone:

OTHERS LIVING IN THE HOME:

Name	Age	Relationship to Client

SCHOOL:

Current School: Grade:

YOUTH'S CURRENT / PAST TREATMENT HISTORY: (if applicable)

Institute / Agency	Dates of Service	Type of Service (in-patient, out-patient)home based therapy)	Discharge Status (successful / unsuccessful)	Tel #	Name of contact

DIAGNOSIS:

Please indicate any DSM V diagnosis and symptoms:

Hx of Suicidal Ideation? Yes ☐ No ☐ Hx of Suicide Attempts? Yes ☐ No ☐

Suicidal Ideation in the last 2 weeks? Yes ☐ No ☐ If yes, explain

Hx of Auditory or Visual Hallucinations? Yes ☐ No ☐ Any Hallucinations in the last 2 weeks? Yes ☐ No ☐

CURRENT MEDICATION(S):

Name	Dose / Frequency	Prescribing Physician

DATE OF INTAKE:

MDFT CLINICIAN ASSIGNED: