

MULTIDIMENSIONAL FAMILY THERAPY REFERRAL FORM

Section I

CLIENT INFORMATION:

Name: _____ DOB: _____

SS#: _____ Gender: _____

Race: African-American or Black American Indian or Native Alaskan Asian
 Native Hawaiian or Pacific Islander White Other: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Primary Language (s) spoken in home: _____

Medical Insurance (plan name and ID#): _____

Section II

REFERRAL INFORMATION:

Referral Type (See last page for a map of towns served):

MDFT – CFA MDFT – UCFS ASSERT – UCFS

Referred by:

Name: _____ Date of referral: _____

Agency: _____ Phone #: _____

Address: _____

DCF Involved: Yes No Status: _____

If Yes:

Social Worker Name: _____ Phone: _____

Area Office/Address: _____

Are there any known/suspected safety concerns in the home? Yes No

(If yes, explain): _____

REASON FOR REFERRAL: _____

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Section III

Current Substance Use: Yes No (If yes, explain): _____

Legal Issues: Yes No (If yes, explain): _____

Section IV

BACKGROUND INFORMATION:

Primary Caretaker(s):

Biological Parent: Yes No Relationship: _____

Caregiver's name: _____ Phone _____

Address: _____

Biological Parent: Yes No Relationship: _____

Caregiver's name: _____ Phone _____

Address: _____

Does child live with primary caretaker(s)? Yes No

If no, adult responsible for the child's care:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Length of time in care with above individual? _____

Reason for removal from primary caretaker? _____

School:

Current School: _____ Grade: _____

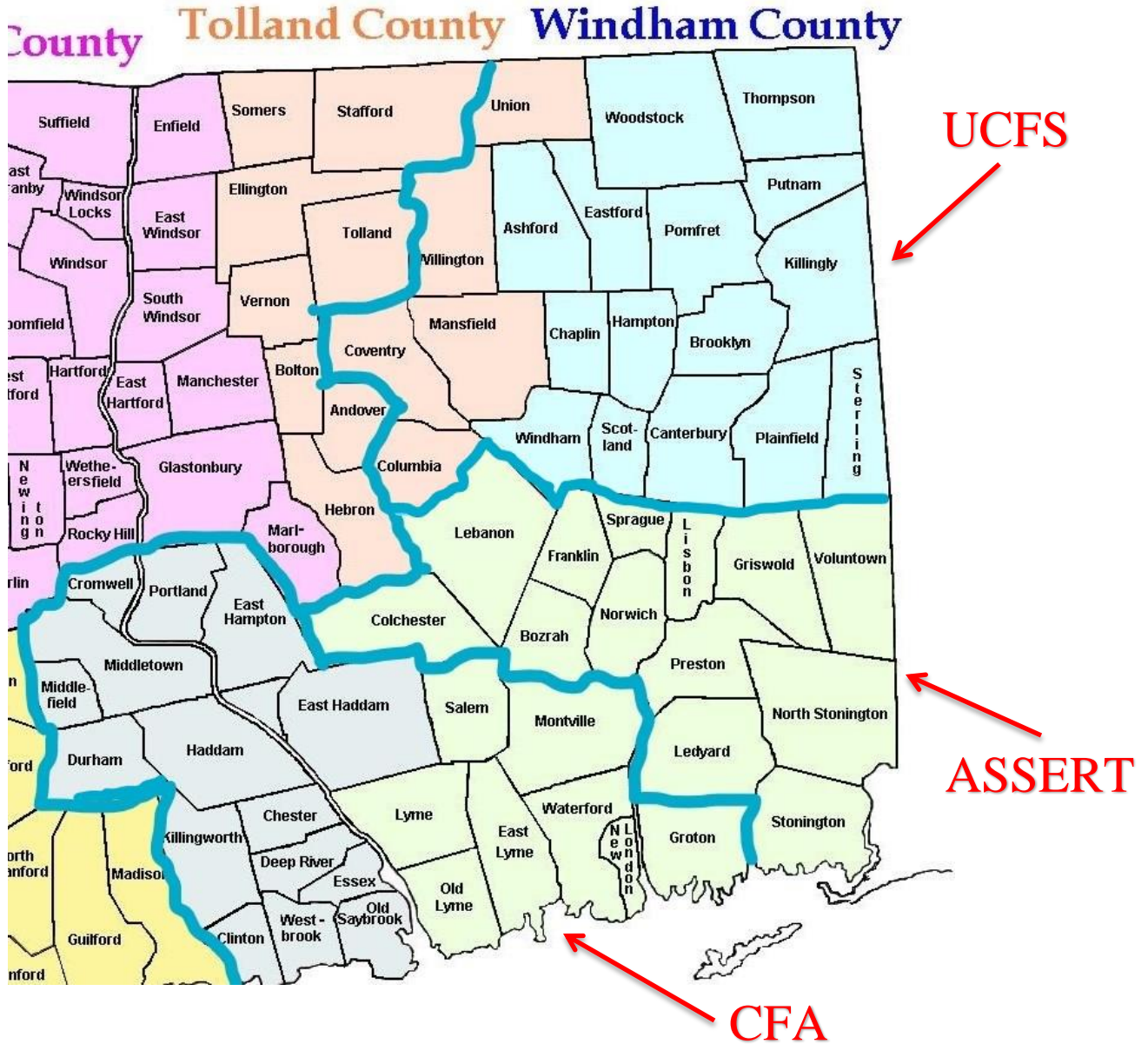
DSM-V Diagnoses:

	Code	Description
I		
II		
III		

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For referrals in need of MDFT services, please refer to this map.

Note: ASSERT team will only cover MDFT referrals when there is capacity; in the event that there is an extensive wait, the referral will be forwarded to the CFA team.



INTERNAL USE ONLY:

Date of Intake: _____ Quadrant (CFA only): _____

Assigned Clinician: _____