M·H·Y FAMILY SERVICES

MST Program Referral Form

1 Referring Professional 2. County/Regional Office 3. Contact Information					
Youth First Name		Youth Last Name			
Date of Referral		Youth DOB		Youth Age	
Sex		Race		Soc Sec #	
MA #		Youth Phone#			
Youth/Family Street Address					
City, State, Zip					

Legal Guardian/Parent of Youth			
Relationship to Youth			
Address		Primary Phone	
City, State, Zip		Alternate Phone	

NAMES OF OTHERS LIVING IN THE HOME:

First Name	Last Name	Age	Relationship to consumer

Treatment Recommendations:	Clinical Concerns: (include frequency, duration, intensity etc.) Referral Behaviors:
Treatment Goals:	

Is Probation Active?	Yes ◉ No ○	P.O.'s Name		Phone	

M·H·Y FAMILY SERVICES

Is child at risk for out of home placement?	◉ Yes ○ No

Is CYF Active?	Yes ◉ No ○	**Case Worker's Name**		**Phone**	

MH/MR Case Mgt.?	Yes ◉ No ○	**Type**	ISC ☐	ICM ☐	RC ☐	ACM ☐
Case Manager's Name			**Phone**			

School		**Home School District**	
School Placement Classification	No IEP ☐	Has IEP ☐	APS ☐

Substance Use or Abuse	
Strengths	
DSM V: **Include: Date of last Evaluation**	
Previous MH Treatment **(Dates, Type & Frequency**	
Current MH Treatment **Dates, Type & Frequency**	

Outpatient MH treatment is inappropriate or insufficient to meet the needs of the child because:

Medication Name	Dosage	Frequency	Prescribing MD

Recommendation:	MST Hrs/Week
Multi-Systemic Therapy (MST)	Contact with the family to match the family/client's clinical need while taken into account length of time in treatment.

Date	Referral Charges	Other Referral Behaviors:
	☐ Theft	☐ Truancy/School Refusal

	☐ Criminal Mischief	☐ Property Destruction
	☐ Arson	☐ Use of alcohol
	☐ Criminal Conspiracy	☐ Use of drug(s): marijuana
	☐ Vandalism	☐ Runaway
	☐ Simple Assault	☐ Curfew Violations
	☐ Aggravated Assault	☐ Verbal Aggression
	☐ Probation Violations	☐ Physical Aggression
	☐ Other:	☐ Other:

MST Therapist	**To Be Assigned:**	**Phone**	
Agency Name	**MHY Family Services: MST Program (Identify County)**		
Address			
MST Supervisor Signature:		**Date**	
Psychologist/Psychiatrist Signature:		**Date**	