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	

Email Address:

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	Email Address

MH/ID	Yes ☐ No ☐		
Service Coordinator's Name		Phone	

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

Substance Use or Abuse	
Client and Family Strengths	
DSM V: Date of Evaluation and Evaluator's name	
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:	Maximum Hours Per Month
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. Maximum of 28 hours per month

Date(s)	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	