Referral Form: MST-PSB

***Please include Written Order or Psych Eval with this form, per IBHS requirement**

*1. Referring Professional 2. Agency 3. Contact Info				*Date of Referral	
*Youth First Name			*Youth Last Name		
Youth Phone #			*Youth DOB	Youth Age	
Sex at Birth		Gender Identity Pronoun Pref.	Race		
MA #			Soc Sec #		
*Guardian/Parent/ Caregiver of Youth					
*Relationship to Youth					
*Address			*County		
*Primary Phone					

***Reason(s) for MST Referral: Check any of the following that are problematic.**

Problem Sexual Behavior *Please attach detailed reports, evaluations, disclosures, etc. if available

- ☐ Problem sexual behavior with siblings or youthful family
- ☐ Other: Please describe:

Youth Behavioral Characteristics	**Youth-School Characteristics**
☐ Verbally aggressive or threatening behavior	☐ Expelled or dropped out of formal education
☐ Robbery, theft	☐ Attending alternative school setting-not mainstream
☐ Vandalism, destruction of property	☐ Multiple suspensions for problem behavior
☐ Drug-related criminal offending	☐ High association with antisocial school peers
☐ Substance use	☐ Poor relationships with school staff
☐ Running away	☐ Attendance problems
☐ Robbery, theft	☐ Academic problems- risk of failure
☐ Non-compliance with probation or court order	☐ Other- describe:
☐ Non-compliance with family rules & expectations	**Youth-Peer Characteristics**
☐ Youth physical health or medical concerns	☐ Gang membership or affiliation
☐ Self-harming behavior	☐ Mixed antisocial and prosocial peers
☐ Violent/physically aggressive behavior	☐ Low affiliation with prosocial peers

*****Indicates the most necessary information

INCLUSIONARY:

- Youth living independently, or youth for whom a primary caregiver cannot be identified.
- Youth in need of immediate psychiatric hospitalization due to threat of harm to self/others, psychosis, suicidal or homicidal thoughts/behaviors (MST-PSB can be appropriate once youth are stabilized).
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism (ASD Level 1 considered on a case-by-case basis).
- Caregivers who deny that problem sexual behavior(s) occurred.

Please direct referral to:

Agency Name	**MHY Family Services: MST PSB**
Primary Address	**521 Route 228 Mars, PA 16046 (Main Campus)**
Contact for More Information	**Director: Lukas Carothers lcarothers@mhyfamilyservices.org**
Phone/Fax	**P: 724-625-3141 F:724-625-2226**