FUNCTIONAL FAMILY THERAPY
THERAPEUTIC CASE MANAGEMENT
REFERRAL FORM

***For FAIR FFT Referrals**, please check the FAIR FFT box at the top of the form and send to FAIRReferrals@cffde.org CC: Rita Fisher, rita.fisher@cffde.org

Referral Date: ______________________ **Referral Time:** __________

Referral Source: ☐ YRS ☐ DFS ☐ Court ☐ School ☐ FAIR ☐ CFF ☐ Self ☐ Other

If Other, please describe: ______________________

Name of Contact: ______________________

Referral Source Address: ______________________

____

Referral Source Phone Number(s): ______________________

Referral Source Fax Number(s): ______________________

Referral Source E-Mail Address: ______________________

Is this Counseling Mandatory? ☐ Yes ☐ No

Identified Youth's Name: ______________________

Youth's DOB: ______________ **Youth's Gender: M F Other:**__________

Youth's Race: ______________________ **Hispanic: Yes** ☐ **No** ☐

Youth's Current Address: ______________________

____

Youth's Phone Number: ______________________

Is above Current Address with Parent(s) or Legal Guardian(s)? ☐ Yes ☐ No

If No, please describe: ______________________

Does Youth have Insurance? ☐ Yes ☐ No **If Yes, Carrier Name:** ______________

Is Youth involved with Other Counseling Services? ☐ Yes ☐ No

If Yes, Name of Agency: ______________________

Is Youth currently on Probation? ☐ Yes ☐ No

If Yes, Name of Probation Officer: ______________________

Probation Officer's Address: ______________________

____

Probation Officer's Phone Number(s): ______________________

Probation Officer's Fax Number(s): ____________________

Probation Officer's E-Mail Address: ____________________

Primary Guardian's Name: ____________________

Primary Guardian's DOB: ____________________

Primary Guardian's Phone Number: ____________________

Primary Guardian's E-Mail: ____________________

Primary Guardian's Address: ☐ **Same as Youth's address**

____

____

Secondary Guardian's Name: ____________________

Secondary Guardian's DOB: ____________________

Secondary Guardian's Phone Number: ____________________

Secondary Guardian's E-Mail: ____________________

Secondary Guardian's Address: ☐ **Same as Youth's address**

____

____

Other children and/or family members residing in the household? ☐ Yes ☐ No

If Yes, First and Last Names, and Relationship to family:	DOB (mm/dd/yyyy):

Please describe the custody/visitation arrangement, if any:

____

____

____

____

____

Who will be participating and what in household will services occur:

____
____
____
____

Reason for Referral: (PLEASE NOTE-IF CASE MANAGEMENT NEEDS ARE SPECIFIED THE FAMILY MUST ALSO MEET ONE OTHER CRITERIA IN ORDER TO BE ACCEPTED FOR SERVICES)

<u>NOTE: All fields need to be completed in order for the referral to be accepted.</u>

☐ Therapeutic Case Management Needs (examples: housing, childcare, employment assistance, other therapeutic needs, etc.)
☐ Peer Problems
☐ Substance Use/Abuse
☐ School related Problems
☐ Family Conflict (rate level below-Required)
  ☐ Mild
  ☐ Moderate
  ☐ Severe

Please Provide Further Details/Notes. If Case Management Needs are identified, please specify:

____
____
____
____
____
____
____
____
____
____
____

*If there are multiple children in the family that will be participating in FFT TCM, please use the oldest child/youth as the identified client**, OR** the child/youth who should be targeted due to highest level of need.

Please send referrals to: FFTReferrals@cffde.org

Questions can be sent to:

Jody.Heisler@cffde.org (administrative support)

Erica.Paul@cffde.org (FFT Supervisor)

Rose.Camps@cffde.org (FFT Program Manager)