CONNECTICUT MULTIDIMENSIONAL FAMILY THERAPY REFERRAL FORM

I.

CLIENT INFORMATION:

Name: _____ DOB: _____

SS#_____ Race: _____

Gender: _____ Primary Language spoken in home: _____

Medical Insurance (plan name and ID#): _____

_____

II.

REFERRAL INFORMATION:

Referred by:

Name: _____ **Date of referral:** _____

Agency/Address: _____

Phone #: _____

AGENCY REFERRED TO:

Agency/Address: _____

Phone #: _____

Probation Supervisor (Signature Req'd for CSSD Post-Dispo)_____

Legal Status:

Court: _____Probation Officer: _____

Current/recent charges: _____

Past charges: _____

Court Orders: _____

Date of Case Review Team Meeting (CRT) **or other team meeting**_____

DCF Involved: Yes _____ No _____ Status:_____

If Yes:

Social Worker Name: _____Phone: _____

Area Office/Address: _____

Any known/suspected safety concerns in the home? (Explain):_____

_____

III.

REASON FOR REFERRAL:

_____

_____

_____

Current Substance use (describe):_____

_____

Supporting Documentation Sent to MDFT (e.g. Evaluations, etc)_____

_____

_____

CONNECTICUT MDFT REFERRAL FORM

IV

BACKGROUND INFORMATION:
Does child live with parent(s)? Yes_____ No_____

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

Name: _____Relationship: _____

Address: _____Phone: _____

PARENTS: **Legal Guardian**

Mother's name: _____ Yes_____ No_____

Address: _____Phone: _____

Legal Guardian

Father's name: _____ Yes_____No_____

Address: _____Phone: _____

OTHERS LIVING IN THE HOME:

Name	Age	Relationship to Client

SCHOOL:
Current School: _____Grade: _____

YOUTH'S CURRENT/PAST TREATMENT HISTORY: (if applicable)

Institute/Agency	Dates of Service	Type of Service (individual therapy, inpatient, outpatient) (home based therapy)	Discharge Status (successful/ unsuccessful)	Tel. #	Name of contact

DIAGNOSIS:
DSM IV Axis I: _____
_____

Axis II: _____
_____

CURRENT MEDICATION:

Name	Dose/Frequency	Prescribing Physician

DATE OF INTAKE: _____

MDFT CLINICIAN ASSIGNED:_____
_____