HARBORCREEK YOUTH SERVICES

Multisystemic Therapy
Referral Information

Youth must meet the following criteria to be considered for MST services:
☐ Youth is age 12-17 years old *(if not, justification is needed)*.
☐ Youth resides in a family setting with a caregiver.
☐ Youth's caregiver is willing to participate.
☐ Youth has active Medical Assistance or is eligible for county authorization.
☐ Youth is exhibiting antisocial/delinquent/externalizing behaviors.
☐ Outpatient services are not sufficient to meet the family's need.
☐ No current homicidal/suicidal ideation/ behavior.
☐ MH Diagnosis *(Mild/Level 1 ASD considered case by case)*

Youth Name:			**Date Referral Presented:**	
Birth Date:	**Age:**	**Gender:** ☐ M ☐ F	**Race:**	**SSN:**
Address:			School District:	
City/State/Zip:			Current School:	
Phone:			☐ Reg-Ed ☐ L.S. ☐ E.S. ☐ Life Skills	Grade:
Medicaid #:			Youth is a: ☐ Dependent ☐ Delinquent ☐ N/A	
Referral Source:			Youth is Returning Home from Placement: ☐ Y ☐ N	
Agency:			Office Phone:	Cell:
Caregiver(s):			Relationship to Youth:	

Other Household Members – Name:	**Relationship to Youth:**	**Age:**

Mother *(if not listed above)*:	Father *(if not listed above)*:
Address:	Address:
Phone:	Phone:

CURRENT SYSTEMS PROVIDING SERVICES:	**PHONE:**
☐ Juvenile Probation Officer/Sup:	
☐ OCY – Case Worker/Supervisor:	
☐ Education Contact Person:	
☐ Drug & Alcohol – Name/Agency:	
☐ ICM / BCM / TCM / RC:	
☐ Mental Health – Name/Agency:	
☐ Physical Health Provider:	

Youth Name:	**Date Referral Presented:**

CURRENT DSM V DIAGNOSIS - Given By:	Date:
Behavioral Health description:	Code:
Behavioral Health description:	
Behavioral Health description:	
Physical Health description:	

Medications	Dosage	Frequency	Prescriber
None			

IDENTIFY CONCERNS: Externalizing / Delinquent / Anti-Social / Substance Abuse / Other:

Date	Referral Charges	Date	Other Referral Behaviors
	☐ Theft		☐ Truancy / School Referral
	☐ Receiving Stolen Property		☐ Property Destruction
	☐ Burglary		☐ Use of Alcohol
	☐ Criminal Mischief		☐ Use of Drug(s)
	☐ Arson		☐ Runaway
	☐ Simple Assault		☐ Curfew Violations
	☐ Aggravated Assault		☐ Physical Aggression
	☐ Probation Violation		☐ Sexually Acting Out Behavior ** PSB at Family Services only
	☐ Inappropriate Sexual Behavior ** PSB at Family Services only		☐ Verbal aggression
	☐ Other:		☐ Other:

DESIRED OUTCOMES (GOALS) FOR REFERRAL TO MST:

PLEASE ATTACH THE FOLLOWING IN YOUR REFERRAL PACKET (IF AVAILABLE):

☐ Court Summary ☐ Education Information ☐ Medical Necessity/Psychiatric/Psychological

Disposition Decision: ☐ Denied for MST Services ☐ Accepted for MST Services

Date Services Initiated: ☐ Family Signed Agreement to Participate