Harborcreek Youth Services
MULTISYSTEMIC THERAPY (MST)
REFERRAL INFORMATION

(MST)

Youth must meet the following criteria to be considered for MST services: (Double click on the box)
☐ Youth is 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 dx Mild/Level 1 ASD considered case by case

Youth Name:			**Date Referral Presented:**	
DOB:	**Age:**		**School District:**	**Grade:**
Address:			**Current School:**	
			Reg-Ed, LS, ES, Life skills	
Phone:	**Gender:**	**Race:**	**Referral Source:**	
MA#:				
Social Sec#:			**Agency:**	
Psych Consult #:			**Phone:**	
☐ **Dependent**	☐ **Delinquent**	☐ **Neither**	**Is youth returning home from a placement? Yes No**	
Caregiver(s):			CURRENT SYSTEMS PROVING SERVICES:	
Caregiver's relationship to youth:			**Juvenile Probation Officer:**	**Phone:**
Other Household Members Name	**Age**	**Relationship**	**JPO Supervisor:**	**Phone:**
			School Based Probation Officer:	**Phone:**
			OCY Supervisor:	**Phone:**
			Education Contact Person:	**Phone:**
			D&A: Name/Agency:	**Phone:**
Mother (If not listed above):			**ICM/RC:**	**Phone:**
Address:	**Phone:**		**MH: Name/Agency:**	**Phone:**
Father (if not listed above):			**Health Provider:**	**Phone:**
Address:	**Phone:**		**Other: Name/Agency:**	**Phone:**

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CURRENT DSM V DIAGNOSIS **Given By:** **Date:**	**Youth Name:**
Behavioral Health description:	**Code:**
Behavioral Health description:	**Code:**
Behavioral Health description:	**Code:**
Physical Health:	**Code:**
Medications:	
	Med Prescriber:

IDENTIFY EXTERNALIZING/DELINQUENT/ANTISOCIAL/SUBSTANCE ABUSE/BEHAVIORAL CONCERNS:

Date

Referral Charges

- ☐ Theft/Receiving stolen property
- ☐ Burglary
- ☐ Criminal Mischief
- ☐ Simple Assault
- ☐ Arson
- ☐ Aggravated Assault
- ☐ Probation Violations
- ☐ Other
- ☐ Charges for Inappropriate Sexual Behavior
  - ➔ Please specify:

Other Referral Behaviors:

- ☐ Truancy/School Refusal
- ☐ Property Destruction
- ☐ Use of Alcohol
- ☐ Use of Drug(s)
- ☐ Runaway
- ☐ Curfew Violations
- ☐ Verbal Aggression
- ☐ Physical Aggression
- ☐ Other
- ☐ Sexually Acting Out Behavior
  - ➔ Please specify:

Desired Outcomes (Goals) for Referral to MST:

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

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

Disposition Decision:

☐ Accepted for MST Services ☐ Family Signed Agreement to Participate

Date Services Initiated: