Family Treatment Program Referral Form

The Family Treatment Program (FTP) provides services to seriously **emotionally** disturbed (SED) children and their families **that live in Washington County**. Our program is an in-home service delivery approach that serves as an alternative to, and diversion from residential, group home or foster care placement.

Four criteria must be met to qualify for services from FTP: 1. The client must be a legal resident of Washington County; 2. the identified client (child or adolescent up to age 18) in the family meets diagnostic criteria for severe emotional disturbance; 3. the identified client is at high risk for placement in residential treatment, group home or foster care placement; and 4. the referral is being made by either Washington County Children's Mental Health Case Management, Washington County Social Worker (CPS, truancy) or Washington County Crisis Response Unit.

Date of Referral:

Reason for Referral:

1. Diversion from: ☐ Residential ☐ Hospital ☐ Group Home ☐ Foster Care

2. Reunification from: ☐ Residential ☐ Hospital ☐ Group Home ☐ Foster Care

Referring Person _____Phone_____

Agency/Facility_____

Child Name_____ DOB _____

Age_____Sex_____Race_____

Parent/Guardian Name _____

Parent/Guardian Phone_____

Family's Address_____
_____

Present Location of
Child_____

Is child adopted? ☐ No ☐ Yes If Yes what age? _____

Has child been diagnosed? ☐ No ☐ Yes If Yes:

Diagnosis_____

By_____

Date_____

Is anger/aggression a problem for this child? ☐ Yes ☐ No

Insurance Company_____Policy Holder_____

ID#_____Group#_____

Legal Status (if known): ☐ Voluntary
Court ☐ Ordered

Type of Petition_____

1. Has family been informed about referral to FTP? Yes ☐ No ☐

2. Is at least one parent interested in involvement with FTP? ☐ Yes No ☐

3. Identify family members:

Name	Relationship to Child	Age	Location

4. Presenting problems for child and family that would necessitate restrictive placement. (List risk factors for the child and family that would warrant this level of therapeutic intervention).

5. Why is in-home therapy needed at this time?

6. Have other less intensive forms of therapy been tried? If yes, with what result?

7. If less intensive therapy has not been attempted, why not?

8. **Current services being delivered**:

- Psychiatrist Name: _____Phone: _____
- Case Manager Name: _____Phone: _____
- County Social Worker Name: _____Phone: _____
- Individual Therapist Name: _____Phone: _____
- Family Therapist Name: _____Phone: _____

☐ Day Treatment Name: _____Phone: _____

☐ Foster Care Name: _____Phone: _____

- Court Services Name: _____Phone: _____
- ☐ Chemical Health Name: _____Phone: _____
- School Case Manager Name: _____Phone: _____
- Other (specify) Name: _____Phone: _____

Do other providers support this referral? _____

9. Previous placement/hospitalization history:

Date	Placement and Length	Outcome

10. a . Medical issues for child and/or family members:

11. Mental health issues for family members:

11. Is the child taking medication? ☐ Yes ☐ No

If yes, what type?

Prescribed by whom?

12. a. Are there chemical health concerns for the child? Yes ☐ No ☐ Unsure ☐
b. Chemical health concerns for family members? Yes ☐ No ☐ Unsure ☐

13. Last school attended: _____

Grade: _____

School Functioning (circle appropriate number):

	Serious Problem									**Not a Problem**
Academic:	1	2	3	4	5	6	7	8	9	10
Behavior:	1	2	3	4	5	6	7	8	9	10

Level of Special Ed. Services: _____

List Behaviors at School:

14. What days and time is family available for in-home appointments:

15. Is there any other information you would like us to know? **Please attach pertinent documents**.

Please mail, email or fax completed referral form to:

Dean Gorall, Ph.D., LMFT
Program Supervisor
In-Home Services/Family Treatment Program
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