**DRUG ABUSE TREATMENT ASSOCIATION, INC.**

Multisystemic Therapy (MST) Program Referral Form

Send Completed form to: MSTreferrals@drugabusetreatment.org

**Youth Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_\_\_ **Referral Date:** \_\_\_/\_\_\_/\_\_\_\_\_

**Phone Number:** \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_ **Address:** Street Address, City, State, Zipcode

**Caregiver Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **School Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Legal Status:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Key Participants** | **Name, Email, Telephone #** |
| [ ]  Referral Source |  |
| [ ]  Parent/Guardian |  |
| [ ]  Household Members |  |
| [ ]  Probation Officer |  |
| [ ]  MH Worker |  |
| [ ]  DCF/Care Worker |  |
| [ ]  Other |  |

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| **Youth Characteristics** *(Check all that apply)* |
| **Youth Behavioral Characteristics** | **Youth-School Characteristics** |
| [ ]  Violent/physically aggressive behavior  | [ ]  Expelled or dropped out of formal education |
| [ ]  Verbally aggressive or threatening behavior | [ ]  Attending alternative school setting – not mainstream |
| [ ]  Robbery, theft | [ ]  Multiple suspensions for problem behavior |
| [ ]  Vandalism, destruction of property | [ ]  High association with antisocial school peers |
| [ ]  Drug-related criminal offending | [ ]  Low affiliation with prosocial school peers |
| [ ]  Substance use | [ ]  Poor relationships with school staff |
| [ ]  Running away | [ ]  Attendance problems  |
| [ ]  Non-compliance with probation or court order | [ ]  Academic problems – risk of failure |
| [ ]  Non-compliance with family rules & expectations |  |
| [ ]  Other: | **Youth-Peer Characteristics** |
| [ ]  Other:  | [ ]  Gang membership or strong affiliation |
| [ ]  Other:  | [ ]  High affiliation with mostly antisocial peers |
| [ ]  Other:  | [ ]  Mixed antisocial and prosocial peers |
| [ ]  Other:  | [ ]  Low affiliation with prosocial peers |

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| **Desired Outcomes for referral to MST services***(Select the red box in areas you see as having highest priority. Please place checkmark in other target areas.)* |
| [ ]  [ ]  Prevent out of home placement. | [ ]  [ ]  Improve family problem solving skills. |
| [ ]  [ ]  Reduce aggressive and/or criminal behaviors. | [ ]  [ ]  Improve family communication and cohesiveness. |
| [ ]  [ ]  Retain school/vocational efforts and/or improve school attendance. | [ ]  [ ]  Improve family behavioral management skills. |
| [ ]  [ ]  Improve academic functioning | [ ]  [ ]  Improve youth pro-social involvement and peer relationships. |
| [ ]  [ ]  Reduce substance use. | [ ]  [ ]  Other:  |
| [ ]  [ ]  Other: | [ ]  [ ]  Other:  |

**Please attach the following in your referral packet (if available):**

[ ]  Summary of Prior Offending [ ]  Recent Mental Health Evaluation [ ]  Recent Educational Evaluation

**Please attach the following in your referral packet:**

[ ]  Release of Information to MST

**Exclusions:**

* Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
* Youth referred primarily due concerns related to suicidal, homicidal, or psychotic behaviors.
* Youths whose psychiatric problems are the primary reason leading to referral, or who have severe/serious psychiatric problems.
* Juvenile sex offenders *(sex offending in the absence of other delinquent or antisocial behavior)*.
* Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.

**Disposition Decision** *(To be Completed by MST Program Staff):*

[ ]  Accepted for MST Program [ ]  Family Signed Agreement to Participate ⬩ Date Services Initiated: Select Date

[ ]  Not Accepted: [ ]  Inappropriate for MST Program [ ]  Service Not Available

[ ]  Other Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by: Approved by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Type Staff Name Date Type MST Supervisor Name Date

