

## Multisystemic Therapy Program (MST) Referral Form

☐ The family has been informed of this referral

Referral Date:	Youth Name:
Date of Birth: Age:	Permanent Address:
Caregiver's phone:	On Probation (Y or N) and charges:
School: Grade:	Gender:
	Race:
<b>Name, E-mail, Phone number</b>	
Referral Source:	
Parent/Guardian/Caregiver:	
Household Members Names and Ages	
Probation Officer:	
Mental Health Worker:	
Social Worker:	
<b>PLEASE CHECK ALL THAT APPLY- Youth Characteristics <i>within the last 12 months</i></b>	
<b>Behavioral</b>	<b>School</b>
<input type="checkbox"/> Violent/physically aggressive behavior	<input type="checkbox"/> Expelled or dropped out of formal education
<input type="checkbox"/> Verbally aggressive or threatening behavior	<input type="checkbox"/> Attending alternative school setting – not mainstream
<input type="checkbox"/> Robbery, theft	<input type="checkbox"/> Multiple suspensions for problem behavior
<input type="checkbox"/> Vandalism, destruction of property	<input type="checkbox"/> High association with antisocial school peers
<input type="checkbox"/> Drug-related criminal offending	<input type="checkbox"/> Low affiliation with prosocial school peers
<input type="checkbox"/> Substance use	<input type="checkbox"/> Poor relationships with school staff
<input type="checkbox"/> Running away	<input type="checkbox"/> Attendance problems
<input type="checkbox"/> Non-compliance with probation or court order	<input type="checkbox"/> Academic problems – risk of failure
<input type="checkbox"/> Non-compliance with family rules & expectations	
<b>PLEASE CHECK ALL THAT APPLY-Youth/Peer characteristics <i>within the last 12 months</i></b>	
<input type="checkbox"/> Gang membership or strong affiliation	
<input type="checkbox"/> High affiliation with mostly antisocial peers	
<input type="checkbox"/> Mixed antisocial and prosocial peers	
<input type="checkbox"/> Low affiliation with prosocial peers	
<b>DESIRED OUTCOMES for referral to MST services</b>	
<b>Please place an "H" in areas you see as having highest priority. Please place checkmark in other target areas.</b>	
<input type="checkbox"/> Prevent out of home placement.	<input type="checkbox"/> Improve family problem solving skills.
<input type="checkbox"/> Reduce aggressive and/or criminal behaviors.	<input type="checkbox"/> Improve family communication and cohesiveness.
<input type="checkbox"/> Retain in school/vocational efforts and/or improve school attendance.	<input type="checkbox"/> Improve family behavioral management skills.
<input type="checkbox"/> Improve academic functioning	<input type="checkbox"/> Improve youth pro-social involvement and peer relationships.
<input type="checkbox"/> Reduce substance use.	<input type="checkbox"/> Other:

\*Has the family ever had a DFPS investigation? (CPS investigation)/ If yes, indicate if the case is open or closed.

☐ Open case    ☐ Closed case: Date of closure \_\_\_\_\_

**PLEASE ATTACH THE FOLLOWING IN YOUR REFERRAL PACKET IF AVAILABLE:**

☐ Summary of Prior Offending    ☐ Recent Mental Health Evaluation    ☐ Recent Educational Evaluation

### PLEASE REMEMBER!

- The family must agree to 2 face-to-face sessions per week in their residence.
  - Adults must be present during MST appointments.
  - The youth must reside in the family home during the entire length of MST, usually 3 to 5 months.
  - The family must agree not to place the youth in RTC or in a relative's home, unless it is an emergency
- Please email this completed form to [mst@dentonmhmr.org](mailto:mst@dentonmhmr.org)
  - Questions? Contact Sherri McCarthy at [sherrim@dentonmhmr.org](mailto:sherrim@dentonmhmr.org) or call 940-390-6805

## For MST use only

Date received:

Date caregiver called:

Outcome:

Date of discharge :

Description of discharge: