HEMPFIELD

BEHAVIORAL HEALTH, INC

INNOVATION ■ COMMUNITY ■ EXPERIENCE

Referral Form for Multisystemic Therapy

Referral Date:	Referring Agency:	Person Making Referral:	Phone # of Referral Source:

Child's Name:			
Date of Birth:	Social Security Number:	Gender:	Race:

Street Address:	City, State, Zip:

County of Residency:	☐ Dauphin County ☐ Cumberland County ☐ Perry County	☐ Snyder County ☐ Northumberland County ☐ Union County	☐ Other:

Who does the Child reside with?	Relationship to Child?

☐ Parent(s) / ☐ Legal Guardian(s) Name(s):

If youth is living with a legal guardian, the custody agreement must be sent with this referral.

Custody Agreement? ☐ YES ☐ NO	Parent/Legal Guardian Phone Number(s):

▪Desired Outcomes for Treatment: Behaviors you would like to see change:

_____

_____

▪Referral has been discussed with the family? ☐ YES ☐ NO Their Response?

_____

_____

▪Previous/Current Programs: Please check all that apply. Include provider name and dates, if known.

☐ Family-Based Therapy:
☐ Foster Care:
☐ Inpatient Psychiatric Treatment:
☐ Juvenile Detention:
☐ Outpatient Family Therapy:
☐ Outpatient Individual Therapy:
☐ Partial Hospitalization:
☐ Residential Treatment:
☐ Shelter:
☐ Wrap Around (TSS, MT, BSC):
☐ Juvenile Probation: P.O.'s Name: Phone:
☐ Children and Youth: C.W. Name: Phone:
☐ Case Management: C.W. Name: Phone:
☐ Medication Management:
☐ Other:

2019 North 2nd Street, Harrisburg, PA 17102
717-221-8004 phone ▪ 717-221-8006 fax

PLEASE FAX ALL REFERRALS TO 717-221-8006

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Child's Name:

▪Safety Concerns in the home? ☐YES ☐NO Describe:
If yes is there a family member that this child can stay with overnight in case of emergency?
Name: Phone # Relationship to Child:

▪Has Youth recently (past 3 months) been in Detention or Placement? ☐YES ☐NO
Date released from Detention or Placement? Detention or Placement Name?

▪Inclusion Criteria Checklist: Place an "X" next to ALL criteria that are relevant to the Youth being referred.

Past 3 Months	Past Year	Criteria	Describe Frequency/Intensity (i.e. daily, 1 time, weekly, etc.)
☐	☐	Involvement in legal system	
☐	☐	Physical Aggression	
☐	☐	Substance Abuse/Use	
☐	☐	Truancy	
☐	☐	Theft	
☐	☐	Verbal Aggression	
☐	☐	Property Destruction/Vandalism	
☐	☐	Runaway	
☐	☐	School Failure	
☐	☐	School Suspensions/School Expulsions	
☐	☐	At Risk of Out-of-Home Placement	

▪Exclusionary Criteria: Place an "X" next to ALL criteria that are relevant to the Youth being referred.

☐ Client Lives Independently ☐ Client is actively psychotic ☐ Client has a diagnosis of autistic disorder
☐ Client is Suicidal ☐ Client is currently homicidal ☐ Sexual offenses are the only presenting problem

▪Current barriers to treatment progress (responsivity factors).

Youth	Parent	Parent Cont'd.	Environment
☐ Cognitive Challenges	☐ Absent Parent	☐ Cognitive Challenges	☐ Financial
☐ Trauma	☐ Custody Concerns	☐ Domestic Violence	☐ Lack of Transportation
☐ Lack of Participation in Treatment	☐ Employment Issues	☐ Lack of Participation in Treatment	☐ Neighborhood Safety Issues
☐ Developmental Challenges	☐ Lack of Phone	☐ Legal Issues	☐ Housing
☐ Physical Health Issues	☐ Mental Health Issues	☐ Parenting Challenges	
	☐ Physical Health Issues	☐ Substance Use/Abuse	

▪YLS Data (JPO Use Only)

YLS Risk Level:	
Youth's 2 Highest Risk Areas:	**1.** **2.**
Drivers (if known)	

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Child's Name:

Additional Relevant Information:

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