Orlando Functional Family Therapy Referral Form

Referral Date:

Date Received (for internal use):

Referrals will be sent back to the referring party if the referral is not completed in its entirety

Youth:

Name: _____

Preferred Name: _____

Age: _____

Date of Birth: / /

Ethnicity: _____

Sex (Circle): Male Female Transgender

Preferred Pronouns (Circle):

He/Him She/Her They/Them

Diagnosis (if applicable):_____

Guardian:

Name: _____

Ethnicity: _____

Relation to Youth: _____

Telephone Number: _____

Email Address: _____

Service Preference (Circle):

☐ Office ☐ Home

Additional Information:

Home Address: _____ Zip Code: _____

Youth School: _____ Grade: _____

Special Education (Y/N): _____

If yes, please specify: _____

Medicaid/Insurance: _____

Referring Party:

Name/Title: _____

Organization: _____

Email/Telephone: _____

Has the family consented to services prior to submission of referral? (Y/N): _____

Confidential Information

Other Interested Parties:

Case Manager: _____ Email/Phone: _____

Juvenile Probation Officer: _____ Email/Phone: _____

Child Protective Investigator: _____ Email/Phone: _____

Other: _____ Email/Phone: _____

If referrals were made to other agencies/organizations/resources, please indicate:

Agency(s) (e.g. Child Protection, Community)	Professional (e.g. OT, Psychologist)
1._____	_____
2._____	_____
3._____	_____

FFT Criteria/Eligibility

Refer to the FFT information sheet or contact the Site Director for questions regarding service eligibility

	Yes	No
1. Does the youth have a formal caretaker/guardian?	☐	☐

If answered no, please explain:

	Yes	No
2. Is the family currently receiving/participating in other services for behavioral health, mental health or and/or substance abuse?	☐	☐

If answered yes, please explain:

	Yes	No
3. Does the youth have a diagnosed or undiagnosed neurodevelopmental condition that would interfere with his/her ability to benefit from FFT?	☐	☐

If answered yes, please explain:

	Yes	No
4. Has the youth been classified as a sexual offender?	☐	☐

If answered yes, please explain and indicate if the youth has attended psychosexual treatment:

Reason for Referral:
Please explain the dynamics of the family, behaviours exhibited by the youth, and any other pertinent information that should be known by the FFT clinician:

Delinquency History:
Please explain the youth's current involvement with the delinquency system to include history of offenses, YSL, and current delinquency status:

Documents Included With Referral Submission:

DCF Documents | School Records | Mental Health Records/Evals | Substance Abuse Evaluation

Psychological/Psychiatric Evaluation | Arrest Reports | Other: _____

Please email referral and all supporting documentation to: baysfamilyconnections@baysflorida.org

INTERNAL USE ONLY

Referral Status (Please Indicate): Accepted ☐ Ineligible/Rejected ☐ Waitlist ☐

Referral Reviewed By: _____ Date: _____

Referral Assigned To: _____ Date: _____