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 intensive, in-home service delivery approach using a co-therapy model and serves as an alternative to, and diversion from, residential placement, correctional placement or extended hospital care.

Two criteria must be met to qualify for services from FTP: **1.** the identified client (child or adolescent up to age 18) in the family meets diagnostic criteria for **severe emotional disturbance**; and **2.** the identified client is at **high risk for placement in residential treatment or hospitalization**.

Date of Referral:

Reason for Referral:

1. Diversion from: ☐ Hospital ☐ Residential ☐ Corrections

2. ☐ Assessment Only

3. Reunification from: ☐ Residential ☐ Hospital

Referring Person ________________________________Phone_____ Agency/Facility__________________

Child Name__________________________ DOB ___________Age___Sex___Race______________________

Family's Address____

Family Phone_______________

Present Location of Child____

Is child adopted?____

Has child been diagnosed? ☐ No ☐ Yes If Yes: Diagnosis_____________________________
By_____________________________________
Date___________________________________

Is anger and 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? ________________________________

How would in-home therapy be linked to the child's total mental health plan? How are parents or primary caregivers involved in current services?

9. Previous placement/hospitalization history:

Date	Placement and Length	Outcome

10. a .Outstanding medical issues for child and/or family members: ________________________________

____

b. 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. If ACE data for parents has been collected, please attach copies.

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

Please mail or fax completed referral form to:

Dean Gorall, Ph.D., LMFT
Program Supervisor
In-Home Services/Family Treatment Program
Canvas Health
7066 Stillwater Blvd. North
Oakdale, MN 55128
Phone: 651-251-5045
Fax: 651-251-5204