# FUNCTIONAL FAMILY THERAPY
# THERAPEUTIC CASE MANAGEMENT
## REFERRAL FORM

**Referral Date:** ______________________ **Referral Time:** ____________

**Referral Source:** ☐ YRS ☐ DFS ☐ Court ☐ School ☐ FAIR ☐ CFF ☐ Self ☐ Other

**If Other, please describe:** ______________________

**Name of Contact:** ______________________

**Referral Source Address:** ______________________

______________________

**Referral Source Phone Number(s):** ______________________

**Referral Source Fax Number(s):** ______________________

**Referral Source E-Mail Address:** ______________________

**Is this Counseling Mandatory?** ☐ Yes ☐ No

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***Identified Child/Youth's Name:** ______________________

**Child/Youth's DOB:** ______________ ☐ **Male** ☐ **Female**

**Child/Youth's Ethnicity:** ______________ **Hispanic:** ☐ Yes ☐ No

**Child/Youth's Current Address:** ______________________

______________________

**Child/Youth's Phone Number(s):** ______________________

**Is above Current Address with Parent(s) or Legal Guardian(s)?** ☐ Yes ☐ No

**If No, please describe:** ______________________

**Does Child/Youth have Insurance?** ☐ Yes ☐ No **If Yes, Carrier Name:** ____________

**Is Child/Youth involved with Other Counseling Services?** ☐ Yes ☐ No

**If Yes, Name of Agency:** ______________________

**Is Child/Youth currently on Probation?** ☐ Yes ☐ No

**If Yes, Name of Probation Officer:** ______________________

**Probation Officer's Address:** ______________________________

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**Probation Officer's Phone Number(s):** ______________________________

**Probation Officer's Fax Number(s):** ______________________________

**Probation Officer's E-Mail Address:** ______________________________

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**Mother's (or Female Guardian's) Name:** ______________________________

**Mother's (or Female Guardian's) DOB:** ______________________________

**Mother's (or Female Guardian's) Phone Number(s):** ______________________________

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**Mother's (or Female Guardian's) E-Mail:** ______________________________

**Mother's (or Female Guardian's) Address:** ☐ Same as Youth's address

______________________________

______________________________

**Father's (or Male Guardian's) Name:** ______________________________

**Father's (or Male Guardian's) DOB:** ______________________________

**Father's (or Male Guardian's) Phone Number(s):** ______________________________

______________________________

**Father's (or Male Guardian's) E-Mail:** ______________________________

**Father's (or Male Guardian's) Address:** ☐ Same as Youth's address

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**Other children and/or family members residing in the household?** ☐ Yes ☐ No

| **If Yes, First and Last Names, and Relationship to family:** | **DOB (mm/dd/yyyy):** |
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**Reason for Referral:** (Check all that apply)

☐ Therapeutic Case Management Needs (examples: housing, childcare, employment assistance, other therapeutic needs, etc.)

☐ Peer Problems

☐ Substance Use/Abuse

☐ School related Problems

☐ Family Conflict (rate level below)

- ☐ Mild
- ☐ Moderate
- ☐ Severe

**Please Provide Further Details/Notes. If Case Management Needs are identified, please specify:**

*If there are multiple children in the family that will be participating in FFT TCM, please use the oldest child/youth as the identified client, OR the child/youth who should be targeted due to highest level of need.

Please send referrals to: Laura.Storck@cffde.org

Please refer questions to: Laura Storck, FFT Program Manager 302-384-0812 (cell) or Laura.Storck@cffde.org