CHILDREN'S COMMUNITY-BASED SERVICES
FUNCTIONAL FAMILY THERAPY REFERRAL FORM

*A completed Written Order (WO), signed by a qualified professional with a clinical license (LCSW, LMFT, LPC, Licensed Psychologist (PsyD or PhD), MD, or DO), is required when recommending FFT. The WO must also be accompanied by this referral form. Please submit all requests through the CBH provider portal. If an agency **does not** have access to the CBH provider portal, submit via secured email to **CBH.ClinicalRequests@phila.gov**.*

For court-involved youth, submit FFT referral via secured email to Tamera Cox at tamera.cox@phila.gov. All other referrals to be submitted via secured email to CBH.ClinicalRequests@phila.gov.

Child Information

Last Name: First Name: Preferred Name:

MA#: SSN#: Age: DOB:

Gender Identity

☐ Girl/Female ☐ Boy/Male ☐ Transgender Female ☐ Transgender Male ☐ Gender Queer

☐ Other: Personal Pronouns:

Race/Ethnicity

☐ African American/Black ☐ Asian/Pacific Islander ☐ Caucasian/White ☐ Latina/Latino/Spanish ☐ Multiracial

☐ Other:

Address and Household Information

Address: City: State: ZIP:

Parent/Caregiver Name: Relationship to Child:

Home #: Work Phone #: Cell #:

Emergency Contact: Phone #: Relationship to Child:

Please provide information regarding the family and other household members

Last Name, First Name	Relationship to Child	Age	Current Services

Relevant Referral Information

Child's Current Services: ☐ AIP ☐ CSU ☐ APHP ☐ CMIS ☐ RTF ☐ IBHS ☐ ABA

☐ CTSS ☐ CIRT ☐ BCM ☐ Outpatient ☐ Other:

Referral Source Name: Agency:

Referral Source Phone #: Referral Source Email Address:

The Youth/Adolescent Demonstrates Risk in One or More of the Following Areas:
List Level of Severity: 0 = No Concern; 1 = Low Concern; 2 = Moderate Concern; 3 = Severe Concern

Area of Risk	Concern Severity	Comments
School Attendance		
School Performance		
Peer Influence		
Substance Abuse		
Family Interaction		
At Risk for Placement		

Presenting Concerns:

DSM 5 Diagnosis:

Conditions requiring special consideration (medical/physical):

Medications:

School: Grade: Special Edu.: ☐ Yes ☐ No

Primary School Contact: Position: Phone #:

Other Systems Information

Current DHS/CUA Involvement: ☐ Yes ☐ No DHS/CUA Worker Name:

Phone #: Cell Phone #: Email Address:

Current Probation Involvement: ☐ Yes ☐ No Probation Officer Name:

Phone #: Cell Phone #: Email Address:

Next Court Date: Needs Written Order? ☐ Yes ☐ No Written Order Attached? ☐ Yes ☐ No

Agreement to Treatment

I, ____, consent to contact between the current and referring provider and the assigned FFT provider to support the intake and treatment process. I agree to regularly attend and engage in in-home family services, which include therapy sessions, and to work cooperatively and collaboratively with members of my family and the assigned team to achieve treatment goals.

Signature of Caregiver Date

Signature of Youth Date