



CHILDREN'S COMMUNITY-BASED SERVICES MULTISYSTEMIC THERAPY FOR PROBLEM SEXUAL BEHAVIOR 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), psychiatric evaluation, and interagency meeting is required when recommending MST-PSB and Traditional Multisystemic Therapy. The WO and evaluation 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.

- MST-PSB Services Traditional MST Services

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: _____

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: _____

Juvenile Court Outcome/Disposition: _____

- Philadelphia Family Court Involvement Other County Court ISPT Meeting Still Needed

Address and Household Information

- Where is Youth Currently Residing? At Home With A Family Member RTF Group Home Foster Care

Other: _____ Permanency Plan if Youth Not Living at Home: _____

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: _____

Presenting Concerns:

DSM 5 Diagnosis:

Conditions requiring special consideration (medical/physical):

Prescribed Medications:

Prescribing Physician: _____ Contact: _____

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

Primary School Contact: _____ Position: _____ Phone #: _____

Any Identified Mental Health/Substance Abuse/Cognitive Concerns Related to the Caregiver(s)?

Primary Physician: _____ Phone #: _____

Address: _____

Identified Victims (Age/Gender/Relationship to Youth/Date of Offense):

Victim(s) Received an Evaluation for Trauma? Yes No Unknown Victim(s) in Therapy for Trauma? Yes No Unknown

If "Yes", Provider Name: _____ Phone #: _____

Has Victim's Therapist Authorized Any Contact with PSB Youth? Yes No Unknown

Summary of Specific Referral Behaviors (including charges as well as behavioral description of the problem sexual behavior):

Other Known Delinquent or Target Behaviors (e.g., substance abuse, trauma, truancy, social/emotional problems, etc.)

Has Youth Received Prior Treatment for Problem Sexual Behavior or Other Target Behaviors? Yes No

If "Yes":

Provider	Dates of Treatment	Contact Person	Phone

Is There an Existing Safety Plan/Relapse Prevention Plan? Yes (please attach) No

Is there at least one adult caregiver in the home committed to actively participate in treatment (i.e. family therapy) with the Youth and willing to enforce a safety plan? Yes No

If "Yes", Caregiver Name: _____ Relationship: _____

Additional Systems Partners Involved:

Agency/Stakeholder	Contact Person	Contact Number	Contact Email

Attached Documents:

- | | | |
|---|--|--|
| <input type="checkbox"/> Court Records/Reports | <input type="checkbox"/> Safety Plan/Relapse Prevention Plan | <input type="checkbox"/> IEP/Education Plan |
| <input type="checkbox"/> Psycho-Sexual Evaluation | <input type="checkbox"/> Other Evaluation | <input type="checkbox"/> Victim Report/Statement |
| <input type="checkbox"/> Other: | | |
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Person Completing Form:

Date:

Phone: