CHILDREN'S COMMUNITY-BASED SERVICES MULTISYSTEMIC 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), psychiatric evaluation, and interagency meeting is required when recommending Multisystemic Therapies. 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 Portal, submit via secured email to **CBH.ClinicalRequests@phila.gov**.*

☐ MST-PSB Services ☐ Traditional MST Services ☐ MST-RSB 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:

- ☐ Court Records/Reports
- ☐ Safety Plan/Relapse Prevention Plan
- ☐ IEP/Education Plan
- ☐ Psycho-Sexual Evaluation
- ☐ Other Evaluation
- ☐ Victim Report/Statement
- ☐ Other:

Person Completing Form:

Date: Phone: