FUNCTIONAL FAMILY THERAPY (FFT)
REFERRAL FORM

Date Received By:

REFERRAL SOURCE:		
Name:	Agency:	Telephone: - -

DEMOGRAPHICS	
Child's Name: Gender: ☐ Female ☐ Male	DOB:
Address:	Telephone: - -
City: State:	Zip Code:
Child's Primary Insurance:	ID#:
Child's Secondary Insurance:	ID#:
***Please be advised that HUSKY is the only insurance that pays in full for FFT. Co-pays /Sliding Fee will be required for privately insured families; however, NO family will be refused services due to financial reasons.**	Annual household income: $
Primary Language: Parent/Caretaker:	Child:
Secondary Language: Parent/Caretaker:	Child:
Parent/Caretaker's Name:	
Address:	
Telephone: Primary: - - Other: - -	
PARENT/CARETAKER'S RELATIONSHIP TO CHILD	
☐ Parent ☐ Foster Parent ☐ Guardian ☐ Relative ☐ Other:	
Have the caregivers been informed about the requirements for family involvement (no individual sessions, meeting at least weekly for at least nine weeks)? ☐ Yes ☐ No	

PERSONS LIVING IN THE HOME WITH CHILD:

NAME	GENDER	DATE OF BIRTH	RELATIONSHIP TO CHILD

ETHNICITY (Check One)**:**

☐ Asian American ☐ Pacific Islander ☐ Hispanic/Latino ☐ Black ☐ White

☐ Native American ☐ Other

CHILD'S CURRENT DCF STATUS (Check One)**:**

☐ Dual Commitment	☐ Committed Abuse/Neglect	☐ Committed Delinquent
☐ Families with Service Needs	☐ Voluntary	☐ No Involvement
☐ Protective Services (Investigation)	☐ Active (Protective Services Case)	

CHILD'S MENTAL HEALTH / MEDICAL ISSUES		
CURRENT DSM-IV DIAGNOSIS	DATE:	BY WHOM:
AXIS I:		
AXIS II:		
AXIS III:		
AXIS IV:		
AXIS V: Current GAF:	Highest in past 6 months:	

CURRENT AND PAST BEHAVIORAL HEALTH TREATMENT PROVIDERS / AGENCIES (DCF, Probation, mental health, etc.)			
NAME OF PROVIDER / AGENCY	TYPES OF SERVICES	DATES OF SERVICES	TELEPHONE NUMBER

Child's Psychiatrist:	Telephone Number:
Child's Therapist:	Telephone Number:
Does the child take any medications? ☐ Yes ☐ No ☐ Unknown **(Meds for physical and/or behavioral health reasons)**	
If yes, please list the medications, if known:	
Child's Pediatrician:	Telephone Number:
OTHER AGENCIES / PROGRAMS INVOLVED WITH CHILD AND SERVICES PROVIDED:	
ANY CURRENT REFERRALS TO OTHER PROGRAMS:	
FAMILY AVAILABILITY: Please list the times/days of the week the family could be available for sessions ☐ Afternoons (before 5:00pm) ________________________ ☐ Evenings (after 5:00pm) ____________________________	
SCHOOL INFORMATION:	
Name of School:	Town:
Contact Person:	Telephone Number:
Special Education: ☐ Yes ☐ No	**Full Scale IQ (If Known):**

REASON FOR REFERRAL:

TRAUMA HISTORY			
HAVE ANY FAMILY MEMBERS BEEN EXPOSED TO ANY OF THE FOLLOWING TRAUMATIC EXPERIENCES? (CHECK ALL THAT APPLY AND INDICATE WHICH FAMILY MEMBER IT PERTAINS TO)			
Physical Abuse:	☐	Community Violence or Victimization:	☐
Sexual Abuse:	☐	Attachment Disruptions/Multiple Placements:	☐
Significant Loss:	☐	Domestic Violence:	☐
Other:	☐ Specify________________	Unknown:	☐

PLEASE DESCRIBE FAMILY'S STRENGTHS (Interpersonal, Community Interests, Other)

***Please include a signed release and any assessments that might be relevant to treatment**