

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. Annual household income: \$  
**Co-pays** will be **required** for **privately insured** families; however, NO family will be refused services due to financial reasons.  
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:

