MST-PSB – Referral Form

Youth's Last Name _____ First Name _____

DOB _____ Gender (M/F) _____ MA# _____ SS# _____

Race/Ethnicity_____

JPO: _____ Phone: _____ Juvenile Court Outcome/Disposition: ___

_____

Parent/Guardian Name _____ Relationship to Youth _____

Email Address_____

Home address _____ City, State, Zip _____

Home phone # _____ Work phone # _____ Cell phone # _____

Other Household Members / Frequent Visitors to the Home

Last Name, First Name	Relationship to Youth	Age

Where is the Youth Currently Residing: ☐ At Home ☐ With A Family Member ☐ RTF ☐Group Home ☐Foster Care

☐ Other: _____ Address: _____

Contact Person/Role: _____ Phone: _____

Permanency Plan if Youth is Not Living in the Home: _____

Mental Health Diagnosis Axis I: _____

Axis II: _____

Is the Youth on Medication? ☐ No ☐ Yes, Medication:_____

Prescribing Psychiatrist: _____ Phone: _____

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

_____

Primary Physician Name, Phone Number & Address_____

School/Address: _____ Grade: _____

Does child receive Special Ed. Services? ___Yes ____No School Contact: _____

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

_____

Has Victim(s) Received an Evaluation for Trauma? ☐ Yes ☐ No ☐ Unknown

Is the Victim in Therapy for Trauma? ☐ Yes ☐ No ☐ Unknown

If "Yes", Name and Phone of Provider: _____

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?** ☐ No ☐ Yes Name/Relationship: _____

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: _____

Please fax completed referral form to Peter Hickok at 215-701-2266