EMERGENCE HEALTH NETWORK
MST PROGRAM - REFERRAL FORM

Referral Date:	Youth Name:
Date of Birth (Age 12-17):	Address:
Tel:	Insurance:
School:	Legal Status:
Youths' Gender:	

Key Participants	**Name, Email, Telephone #**
[ ] Referral Source:	
[ ] Parent/Guardian/Caregiver:	
[ ] Household member names:	
[ ] Probation Officer:	
[ ] MH Worker:	
[ ] Social Services/ Care Worker:	
Primary Language Parents Speak:	

Youth Behavioral Characteristics	**Youth-School Characteristics**
[ ] Violent/physically aggressive behavior	[ ] Expelled or dropped out of formal education
[ ] Verbally aggressive or threatening behavior	[ ] Attending alternative school setting – not mainstream
[ ] Robbery, theft	[ ] Multiple suspensions for problem behavior
[ ] Vandalism, destruction of property	[ ] High association with antisocial school peers
[ ] Drug-related criminal offending	[ ] Low affiliation with prosocial school peers
[ ] Substance use	[ ] Poor relationships with school staff
[ ] Running away	[ ] Attendance problems
[ ] Non-compliance with probation or court order	[ ] Academic problems – risk of failure
[ ] Non-compliance with family rules & expectations	
	Youth-Peer Characteristics
[ ] Other:	[ ] Gang membership or strong affiliation
[ ] Other:	[ ] High affiliation with mostly antisocial peers
[ ] Other:	[ ] Mixed antisocial and prosocial peers
[ ] Other:	[ ] Low affiliation with prosocial peers

Desired Outcomes for referral to MST services **Please place an "H" in areas you see as having highest priority. Please place checkmark in other target areas.**	
[ ] _____ Prevent out of home placement.	[ ] _____ Improve family problem solving skills.
[ ] _____ Reduce aggressive and/or criminal behaviors.	[ ] _____ Improve family communication and cohesiveness.
[ ] _____ Retain in school/vocational efforts and/or improve school attendance.	[ ] _____ Improve family behavioral management skills.
[ ] _____ Improve academic functioning	[ ] _____ Improve youth pro-social involvement and peer relationships.
[ ] _____ Reduce substance use.	[ ] _____ Other:
[ ] _____ Other:	[ ] _____ Other:

PLEASE ATTACH THE FOLLOWING IN YOUR REFERRAL PACKET IF AVAILABLE

[ ] Summary of Prior Offending [ ] Recent Mental Health Evaluation [ ] Recent Educational Evaluation

EXCLUSIONS:

- Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
- Youth referred primarily due concerns related to suicidal, homicidal, or psychotic behaviors.
- Youth referred primarily due to having severe psychiatric problems (youth who have psychiatric problems may be referred however, this cannot be the primary reason for referral)
- Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior).
- Youth with pervasive developmental delays and low cognitive functioning youth

PLEASE LIST ANY SAFETY CONCERNS:

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SUMMARY

Please add a summary explaining any relevant information regarding any legal charges, aggression, disobedience, school failure, school behaviors, truancy, issues related to peers, substance abuse, etc.
****JPD you can add a Pre-Disposition Report if available.**

Disposition Decision (To be Completed by MST Program Staff):

[ ] Accepted for MST Program [ ] Family Signed Agreement to Participate - Date Services Initiated :
[ ] Not Accepted: [ ] Inappropriate for MST Program [ ] Service Not Available [ ] Other Reason: