



## Osceola/Brevard FFT Referral Form

Referrals will be sent back to the referring party if the referral is not completed in its entirety

Referral Date: \_\_\_\_\_

Date Received (for internal use): \_\_\_\_\_

County of Service:

Osceola      Brevard

Youth:
Name: _____
Preferred Name: _____
Age: _____
Date of Birth:    /    /
Ethnicity: _____
Sex (Circle):    Male    Female    Transgender
Preferred Pronouns (Circle): He/Him      She/Her      They/Them
Diagnosis (Required): _____

Guardian:
Name: _____
Ethnicity: _____
Relation to Youth: _____
Telephone Number: _____
Email Address: _____
Service Preference: Office      Home

Additional Information:
Home Address: _____ Zip Code: _____
Youth School: _____ Grade: _____
Special Education (Y/N): _____
<i>If yes, please specify:</i> _____
Medicaid/Insurance: _____

Referring Party:
Name/Title: _____
Organization: _____
Email/Telephone: _____
Has the family consented to services prior to submission of referral? (Y/N): _____



Other Interested Parties:	
Case Manager: _____	Email/Phone: _____
Juvenile Probation Officer: _____	Email/Phone: _____
Child Protective Investigator: _____	Email/Phone: _____
Other: _____	Email/Phone: _____
If referrals were made to other agencies/organizations/resources, please indicate:	
Agency(s) (e.g. Child Protection, Community)	Professional (e.g. OT, Psychologist)
1. _____	_____
2. _____	_____
3. _____	_____

FFT Criteria/Eligibility:	
<b>Refer to the FFT information sheet or contact the Site Director for questions regarding service eligibility</b>	
1. Does the youth have a formal caretaker/guardian?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If answered no, please explain:</i>	
2. Is the family currently receiving/participating in other services for behavioral health, mental health or and/or substance abuse?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If answered yes, please explain:</i>	
3. Does the youth have a diagnosed or undiagnosed neurodevelopmental condition that would interfere with his/her ability to benefit from FFT?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If answered yes, please explain:</i>	
4. Has the youth been classified as a sexual offender?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If answered yes, please explain, and indicate if the youth has attended psychosexual treatment:</i>	

**Reason for Referral:**

*Please explain the dynamics of the family, behaviors exhibited by the youth, and any other pertinent information that should be known by the FFT clinician:*

**Delinquency History:**

*Please explain the youth's current involvement with the delinquency system to include history of offenses, YSL, and current delinquency status:*

**Documents Included with Referral Submission:**

- DCF Documents
- School Records
- Mental Health Records/Evals
- Substance Abuse Evaluation
- Psychological/Psychiatric Evaluation
- Arrest Reports
- Other: \_\_\_\_\_

**Please email referral and all supporting documentation to: [bfc-osceola@bayskids.org](mailto:bfc-osceola@bayskids.org)**

**INTERNAL USE ONLY**

Referral Status (Please Indicate):

Accepted

Ineligible/Rejected

Waitlist

Referral Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Referral Assigned To: \_\_\_\_\_ Date: \_\_\_\_\_