MULTISYSTEMIC THERAPY
Referral Screening Form

Completed Referrals should be sent to Amy Wilkins either by fax to 629-9091 or email mstreferrals@kbhmaine.org for additional questions please call Amy Wilkins at 207-626-3455

IS MST THE "RIGHT FIT" FOR THE FAMILY? Please insure family understands all items listed below prior to referral:

___ Family understand that MST therapist will work primarily with parents to make changes in their child's ecology? MST does not work individually with the youth

____ Family understands that MST will continue to work with caregivers even if youth refuses to participate in sessions

____ MST therapists/ on-call is available to families 24/7 while they are open to the program for support

_____ Families understand that MST is an intensive program and that they will have to meet with their therapist at least 2 times per week for minimum of 4 hours per week for MST and MSTPSB requires families to meet for 3 sessions a week for a minimum of 6 hours a week. MSTCM meets for a minimum of 4 hours a week or 2 or more sessions a week.

____ Does the family understand that while receiving MST Services they may have stop other services such as individual counseling; group counseling etc.

____ Does the family and team agree to not place the youth in a more restrictive setting for the duration of the program which is 5 months for MST and 7 months for MSTPSB

We cannot take referrals for youth who meet criteria below*:

1. 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 caregiver.
2. Youth referred primarily due to concerns related to active suicidal, homicidal or psychiatric behaviors.
3. Youth who present primarily with internalizing disorders (such as anxiety disorders, depressive disorders, eating disorders, etc.) or who present with thought disorders.
4. Youth who are on the Autism spectrum unless diagnosed as LEVEL ONE (additional screening still required)
5. Youth for whom an out of home placement is in process.

*MST is an evidenced based model and we have created this checklist to help screen youth and families so that fidelity to the model can be maintained.

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Date of Referral:_____

Type of Service Requested:
☐ MST
☐ MST-PSB
☐ MST-CM

Contact Information:

Name(person completing form) Agency:

Name of Children's Targeted Case Manager:

Office Location/Address:

Phone #: EXT: Cell Phone #:

Demographics of Child: (Child's name spelled as it appears on the MaineCare card)

First: Middle: Last: Gender: ☐ M ☐ F

DOB: SS #: Maine Care #: Race: (optional)

Child's Current Residence:

Street: Town:

ME Zip: Phone #: Cell Phone #:

Legal Guardian(s): Name & Mailing Address Phone #: Cell Phone #:	**Guardian(s) Custody:** Married ☐ Yes Sole ☐ Yes
Shared Custody: Name & Mailing Address Phone #: Cell Phone #:	Shared ☐ Yes fill in name/address DHHS ☐ Yes Own ☐ Yes

Child Primary Language: Caregiver's Primary Language:

Does this family utilize interpreters services ☐ Yes ☐ No

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Name of Interpreter & Contact information:

Primary Diagnosis: Axis I: Axis II: D/C 0-3

Diagnosis Provided By: Credentials: Date of DX:

Does child have developmental delays, Intellectual Disabilities, Autism, or Early Intervention? ☐ Yes (If yes please explain) ☐ No

Does child have any significant physical disabilities? ☐ Yes (If yes please explain) ☐ No

Primary Reason for referral:

Which of the following behaviors does the child display: check all that apply

	Verbal Aggression		Threatening
	Physical Aggression		Truancy
	Active Defiance		School Work Refusal
	Property Destruction		Substance Use/Abuse
	Engaged with Negative Peers		Problem Sexual Behavior
	Oppositional Behaviors		Criminal Behaviors
	Risk of failure at school due to behaviors		Ongoing Family Conflict
	Serious Disrespect and Disobedience		Running Away
	Fire Setting		Self-injurious or Suicidal
	Abusive to Animals		Police Involvement
	Dangerous Impulsivity		Night terrors or sleep disturbance
	Child Isolated		Use of Crisis services
	Soil, smear feces or urinate in inappropriate places		Other: Please explain:

How are these behaviors affecting your family:

Service History:

1.Is child currently placed in residential treatment or foster/kinship care ?

☐ Yes (If yes please explain) ☐ No

2. Has the child been involved in the Juvenile Justice System?

☐ Yes (If yes please explain) ☐ No

3. Has the child been reviewed by the Intensive Temporary Residential Treatment team in the last 6 months?

☐ Yes (If yes please explain) ☐ No

4. Has the child utilized individual therapy?

☐ Yes (If yes please explain) ☐ No

5. Has the child utilized RCS 28 services?

☐ Yes (If yes please explain) ☐ No

Please list prior treatment received:

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Current Services:

1. Is the youth at risk for out of home treatment or transitioning home from an out of home treatment?
☐ Yes (If yes please explain) ☐ No

2. Has the family had child protective involvement in the past 6 months?
☐ Yes (If yes please explain) ☐ No

3. Has the family had HCT, MST, or FFT in the last 6 months**?** ☐ Yes (IF yes, Please provided information regarding other services accessed, barriers to progress, what has change, and how service is anticipated to benefit family at this time) ☐ No

Please list all current services:

What would child & parent like to see from treatment:

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Release of Information

In order for Treatment to proceed the following Parental/Guardian Approval must be granted. (Please initial after each statement and sign below in Parent/Guardian section)

As the parent/guardian of this child (or self, when own guardian),

1. I agree with the proposed intensive in home child and family treatment service. _____
2. I agree to actively participate in this treatment that includes: family meetings, family therapies, individual therapy, as indicated._____
3. I agree to the release of the information contained within this application, but only to a receiving provider agency as part of the treatment planning process. _____
4. I have reviewed all information contained in this document and attest that it is true to the best of my knowledge. _____

My signature below indicates my approval of all the above-initialed statements.

Parent/Guardian: Date:

*** It is highly recommended to attach the child's most recent Diagnostic Evaluation to speed up the process.**