MULTI-SYSTEMIC THERAPY (MST)
REFERRAL FORM

MST is an evidence-based in-home family treatment for youth with complex clinical, substance using, social, and educational problems. MST emphasizes behavioral change in the natural environment and uses interventions to promote the parent's capacity to monitor and intervene positively with each youth. To make a referral, please call or fax this form to the provider in your area.

☐ **Wheeler Clinic**- (tel.) 860-803-4195 (fax) 860-793-4440 (New Britain, Hartford, and Manchester areas)

Youth Referral date:

First name:	Last name:	Date of birth:
Age:	Race/ethnicity:	Gender:
Address:		Cell phone:
Youth resides with:		Relationship:
School:	Grade:	Primary language:
Insurance:		Policy number:

Caregiver/Guardian

Caregiver name:	Last name:	Primary Language:
Phone number:		Cell phone:
Address:		
Legal guardian's name:	Last name:	Primary language:
Phone number:		Cell phone:
Address:		

Youth Concerns

Has the youth demonstrated any of the following behaviors: ☐ physical aggression, ☐ verbal aggression, ☐ AWOL, ☐ arrest, ☐f ire setting, ☐ property destruction, ☐ stealing, ☐ truancy?
List substances used within the past month: _____ ☐ No substance use due to being in a controlled environment
Youth is currently using substances as evidenced by: ☐ self-report, ☐ positive urinalysis, ☐ police report, ☐ witness of use, ☐ other _____
Substance use and/or behavioral health have negatively impacted: ☐ relationships, ☐ family, ☐education, ☐ health, ☐ legal, ☐ interests, ☐other_____

Diagnosis:
Identified Recovery Supports: ☐ Family, ☐ Friends, ☐ Faith-Based, ☐ Educational, ☐ Basic Needs, ☐Transportation, ☐ Legal, ☐ Other _____
Is the family ☐ willing to accept treatment, ☐ somewhat resistant, or ☐ resistant to treatment?
List other pending referrals:

Reason for referral

Form Completed By:

First name:	Last name:	Agency (if applicable):
E-mail:		Phone number: