CENTRAL COUNTIES SERVICES

MEETING BEHAVIORAL AND DEVELOPMENTAL NEEDS

MST PROGRAM REFERRAL FORM

Referral Date:	Youth Name:
Date of Birth (Age 12-17):	Address:
Tel:	
School:	Legal Status:
Key Participants	**Name, Email, Telephone # (for each)**
[ ] Referral Source:	
[ ] Parent/Guardian/Caregiver:	
[ ] Household member names:	
[ ] Probation Officer:	
[ ] MH Worker:	
[ ] Social Services/ Care Worker:	

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.
- Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
- Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior).
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.

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: