|  |
| --- |
| **EXCLUSIONS:** *Please review exclusions before completing this referral* |
| * 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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **YOUTH / FAMILY INFORMATION** | | | |
| Referral Date: | Youth Name: | | |
| Date of Birth (Age 12-17): | Address: | | Jurisdiction: |
| Tel: | City: | State: | Zip: |
| Legal Status: | School: | | |
| Funding Source: (dropdown here) | PO#: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please list all key participants:** | | | |
| **Key Participants** | **Name** | **Email** | **Phone#** |
| Referral Source: |  |  |  |
| Parent/Guardian/Caregiver: |  |  |  |
| Household member names: |  |  |  |
| Probation Officer: |  |  |  |
| CSB Rep: |  |  |  |
| DFS Rep: |  |  |  |
| School Rep: |  |  |  |
| Family Support Partner |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please place an “H” in areas you see as having highest priority. Please place “T” in other target areas.** | | | |
| **Desired Outcomes for referral to MST services** | | | |
| NA | Prevent out of home placement. | NA | Improve family communication and cohesiveness. |
| NA | Retain in school/vocational efforts | NA | Improve family problem solving skills. |
| NA | Improve school attendance. | NA | Improve family behavioral management skills. |
| NA | Improve academic functioning | NA | Reduce substance use. |
| NA | Improve youth pro-social involvement and peer relationships. | NA | Reduce aggressive and/or criminal behaviors. |
| NA | Other: Click or tap here to enter text. | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please check all that apply** | | | |
| **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 |
|  | Drug 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: Click or tap here to enter text. |
|  | High affiliation with mostly antisocial peers |  | Other: Click or tap here to enter text. |
|  | Mixed antisocial and prosocial peers |  | Other: Click or tap here to enter text. |
|  | Low affiliation with prosocial peers |  | Other: Click or tap here to enter text. |

|  |
| --- |
| **PLEASE ATTACH THE FOLLOWING IN YOUR REFERRAL PACKET IF AVAILABLE** |
| Summary of Prior Offending  Recent Mental Health Evaluation  Recent Educational Evaluation  CSA Consent to Exchange Information with MST  Meeting Action Plan (MAP)  IFSP / Plan of Care  CANS |

|  |
| --- |
| **Disposition Decision (t*o be completed by MST Program Staff):*** |
| Accepted for MST Program Family Signed Agreement to Participate - Date Services Initiated: Click to enter a date. |
| Not Accepted:  Inappropriate for MST Program  Service Not Available  Other Reason: |

**Please submit referral to:**

National Counseling Group (Manassas Office)

9301 Forest Point Circle Manassas, VA 20110

**Email**: [referral@ncgcare.com](mailto:referral@ncgcare.com) **Phone**: 703-257-5997 **Fax**: 703-257-7518