VERA FRENCH
Mental Health for Healthy Living

Multi-Systemic Therapy (MST) Program
Referral Information Sheet

To be completed and emailed to Jessy Bartz – MST Supervisor at BartzJ@verafrenchmhc.org
For referral questions, please call 563 396-3231

Referral Date:	Youth Name:
Date of Birth (Age 12-17):	Address: County:
Tel:	
School:	Legal Status:

Key Participants	**Name, Email, Telephone #**
☐ Referral Source:	
☐ Parent/Guardian/Caregiver:	
☐ Household member names:	
☐ Probation Officer:	
☐ MH Worker:	
☐ Social Services/ Care Worker:	
☐ Medicaid Number:	
☐ # of units authorized:	
☐ Insurance carrier:	

MST-Eligible Youth Characteristics *(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
☐ 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**
Intensity: ☐ Low ☐ Moderate ☐ High	☐ 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 check all areas you see as having highest priority.

☐ 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:

PLEASE ATTACH THE FOLLOWING IN YOUR REFERRAL PACKET IF AVAILABLE
☐ Summary of Prior Offending ☐ Recent Mental Health Evaluation ☐ Recent Educational Evaluation

EXCLUSIONS: (The following youth would generally NOT be eligible for MST)

- 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

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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:

Review Date:_____

Reviewer:_____

Notified Referral Source Date: _____