Family Centered Treatment (FCT) Referral Form

Referral To: _____ Date of Referral: _____
Provider Name: _____ Provider Phone #: _____
Provider Email: _____

Client Information

Please complete the following information:

Name of Person Served/Client: _____ DOB: _____
Preferred Name: _____ Age: _____

Medications Name	Dose of Medication	Reason for Medication

Diagnosis Information: _____

Insurance Carrier: _____ Policy Number: _____

Medical Conditions/Allergies: _____

Caregiver Information

Caregiver Name: _____ Caregiver Phone #: _____
Caregiver Email: _____
Caregiver Address: _____
Person served/client is also a caregiver? ☐ Yes ☐ No
Who does the child live in the home with: ☐ Biological/ Adoptive ☐ Foster ☐ Kinship ☐ Other : _____

Race
☐ African American/Black ☐ Pacific Islander ☐ Asian
☐ White/Caucasian ☐ Native American/Alaskan Native
☐ Prefer not to answer ☐ Other: _____

Ethnicity
☐ American Indian/Alaska Native ☐ More than one race (non-Hispanic) ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Caucasian/White ☐ Hispanic or Latino
☐Black or African American ☐ Other: _____

Gender
☐ Female ☐ Non-Binary (female at birth) ☐ Transgender (female to male)
☐ Male ☐ Non-Binary (male at birth) ☐ Transgender (male to female)

System Involvement

What is the youth's involvement in Juvenile Justice? ☐ N/A ☐ Pre-Court ☐ Probation ☐ Aftercare/re entry

Is this family involved with child welfare/social services? ☐ Yes ☐ No

Other than the referred client/youth are any other children in the home Juvenile Justice involved? ☐ Unknown ☐ Yes ☐ No

Referral Source

Check the type of agency making the referral (select one)

☐ CAC/Child Advocacy Center	☐ Managed Care Organization	☐ Social Services	☐ Juvenile Justice – Pre-Court
☐ Crisis Facility/Crisis Service	☐ Outpatient Provider/Case Management	☐ Self/Family Member	☐ Juvenile Justice -Probation
☐ Group home/ Residential Treatment Center	☐ School System	☐ Primary Care/Pediatrician	☐ Juvenile Justice - Aftercare/Re entry
☐ Hospital	☐ Other: _____		

Reason for Referral

Check the general problem(s) that prompted this referral. Check all that apply.

☐ Trauma	☐ Sexual Abuse	☐ Substance Use
☐ Neglect	☐ Sex Offense	☐ Poverty/Economic Hardship
☐ Basic needs not being met	☐ School Problems	☐ Pregnant or Parenting Teen
☐ Domestic Violence	☐ Juvenile Delinquency	☐ Parenting Skills
☐ Emotional Abuse	☐ Mental/Behavioral/Emotional Health	☐ Child Well Being
☐ Physical Abuse	☐ Medical Problems	☐ Other (Please specify)

Number of Hospitalizations in the past 6 months: _____

Person Served or child of Person Served is at imminent risk for out-of-home placement or plan for reunification is at-risk: (Imminent risk of out-of-home placement refers to the situation where, **if behaviors do not change,** the person served or child of the person served would be placed out-of-home. If a Reunification referral, similarly, assess whether the person served is at risk of remaining in/returning to an out-of-home placement if the reunification fails.) ☐ Unknown ☐ Yes ☐ No

Signature and Credentials _____ Date _____

Please send referrals to crystal.ludtke@arrow.org or reach out to arrow.org for more information.