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 ☐ Kinship ☐ Foster ☐ 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.