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MST REFERRAL FORM

Please complete & send to **referral@aboutchangeva.com** or fax to 571-659-0056

Referral Date:	Youth Name:
Date of Birth (Age 12-17 only):	Address:
Contact Number:	
School:	Legal Status:

Key Participants	**Name, Email, Telephone #, Address (*optional*)**
☐ Referral Source:	
☐ Parent/Guardian/Caregiver:	
☐ Household member names:	
☐ Probation Officer:	
☐ MH Worker:	
☐ Social Services/ Case Worker:	

Youth Behavioral Characteristics (check all that apply)	**Youth-School Characteristics** (check all that apply)
☐ 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** (check all that apply)
☐ Other:	☐ Gang membership or strong affiliation
	☐ High affiliation with mostly antisocial peers
☐ Other:	☐ Mixed antisocial and prosocial peers
	☐ 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 "X" 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.
☐ Improve family behavioral management skills.	☐ Retain in school/vocational efforts and/or improve school attendance.
☐ 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

Referring Entity Information

Referring Entity/Person: _____ Phone: _____ Fax: _____

Signature: _____ Email: _____

Disposition Decision (*To be Completed by MST Program Staff*):

☐ Accepted for MST Program ☐ Family Agreed to Participate - Date Services Initiated: _____

☐ Not Accepted: ☐ Inappropriate for MST Program ☐ Other Reason: _____