MST Referral/Intake Assessment

Completed By:

Submit to: MST Program Coordinator
Fax:
Phone: 806-740-1462

1 Referring agency, 2 Worker name, and 3 County							
First Name				Last Name			
Date of Assessment				DOB		Age	
Sex		Race		Soc Sec #			
MA #				Phone			
Street Address							
City, State, Zip							

Legal Guardian/Parent			
Relationship to Consumer			
Address		Primary Phone	
City, State, Zip		Alternate Phone	

LIST ALL OTHERS IN THE HOME:

First Name	Last Name	Age	Relationship to consumer

DIAGNOSIS:
By: Date:

Diagnosis	
Diagnosis	
Diagnosis	
Diagnosis	

Treatment Recommendations/Goals:	Clinical Concerns: (include frequency, duration, intensity etc.) JPO/CYS Referral Behaviors:

Probation Active?	Yes ☐ No ☐	**P.O.'s Name**		**Phone**	
Children Youth Services Active?	Yes ☐ No ☐	**Case Worker's Name**		**Phone**	

MH/MR Case Mgt.?	Yes ☐ No ☐	**Type**	ISC ☐	ICM ☐	RC ☐	ACM ☐
Case Manager's Name			**Phone**			

School		**Home School District**	
School Placement Classification	No IEP ☐	Has IEP ☐	APS ☐

Substance Use or Abuse	
Strengths	
Referral Concerns	
Previous MH Treatment (Dates, Type & Frequency	
Current MH Treatment **Dates, Type & Frequency**	

Medication Name	Dosage	Frequency	Prescribing MD

Is child at risk for out of home placement?	☐ Yes ☐ No

Recommendation:	**MST Service Hours per Week**
Multi-Systemic Therapy (MST)	Minimum of 2 hours Direct Contact per week for 3 to 5 months

Date	**Referral Charges**	**Other Referral Behaviors:**
	☐ Theft	☐ Truancy/School Refusal
	☐ Criminal Mischief	☐ Property Destruction
	☐ Arson	☐ Use of alcohol
	☐ Criminal Conspiracy	☐ Use of drug(s): marijuana
	☐ Vandalism	☐ Runaway
	☐ Simple Assault	☐ Curfew Violations
	☐ Aggravated Assault	☐ Verbal Aggression
	☐ Probation Violations	☐ Physical Aggression
	☐ Other:	☐ Other:

MST Therapist		**Phone**	
Agency Name			
Address			
MST Supervisor Signature:		**Date**	