Support is all around you
SYSTEM OF CARE | ST. LOUIS REGION

Vision for CHILDREN at Risk

Family Support Project | Referral Form

FAMILY Information Date:

Youth Name

Primary Parent or Caregiver Name

☐ **School District**

☐ **Age** Date of Birth

Street Address

Zip Code Phone

Email

Please list any services or organizations the client/family are currently working with:

Current services ☐ BJC ☐ DJO ☐ Places for People

☐ People's ☐ Youth in Need ☐ Children's Division

Other:

Case Manger/CCS/DJO Contact:

Phone Email

MENTAL HEALTH Information

☐ **Youth: mental health condition that substantially interferes with functioning in family, school or community activities.**

Diagnosis

Signs and Symptoms

Source: ☐ court records ☐ self-report ☐ observation

Comments:

☐ **Parent or Adult Caregiver**: ☐ Unmet mental health needs ☐ Interested in services

☐ Further screening recommended

Referral Source:

Contact Information:

Additional information about youth/family**:**

Office Use Only

REFERRAL Process

Step 1: Receive referral

Step 2: Staff referral with Family Support Partner

Step 3: Contact family for engagement

A: Integrated Family Treatment (SOC project)

- ☐ School Partnerships
- ☐ Children's Division
- ☐ People's Health Center
- ☐ BJC

TRACKING Process

Insert dates in the boxes as they are completed.

1. ☐ Date on Referral Form
2. ☐ Date assigned FSP
3. ☐ Date referred from BHR
4. ☐ Date of intake at Service Provider (CMHB, Therapist, etc.)