



REFERRAL FOR MULTIDIMENSIONAL FAMILY THERAPY (MDFT)

Youth Name:		Date:	
Youth Date of Birth:		Caregiver Phone:	
Caregiver Name:		Relationship to Client:	
Address:			
Referred by:		Referred phone number:	

MDFT can be provided to youth who:

- ☐ Are between the ages of 9 – 17.5
- ☐ Have Idaho Medicaid
- ☐ Have at least one caregiver who is willing to participate in the program.

Does the youth experiences any of these behaviors or mental health concerns (check all that apply):

- ☐ Symptoms of emotional distress (i.e. irritability, severe change in sleep and/or eating patterns, panic attacks, hypervigilance, dissociation, and self-harm, etc.).
- ☐ Substance use
- ☐ Illegal behaviors
- ☐ Attempts to harm or intimidate others, such as aggressive behaviors at home or school.
- ☐ Youth is returning home from out-of-home placement (e.g. foster care, IDJC commitment, group home).

Has the youth been involved in any of these settings:

- ☐ Juvenile Probation
- ☐ Respite or Crisis placement (e.g. Bannock House)
- ☐ Hospitalization/Residential Treatment Center
- ☐ Child Protection Services/Foster Care
- ☐ Residential Behavioral Program (e.g. Challenge Academy)
- ☐ Residential substance use treatment

Please include any additional information:

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