MST Referral Form Referral Date:			
Date of Birth (Ages 12-17):	**Race/Ethnicity:**		
Name of youth being referred:			
School:			
Parent/Guardian Name & Phone No.:		**Latest IQ Score:**	
Address:			
Youth Social Security Number:			
Referral Source			
Internal BHC Staff Name:	**Position:**	**Current LOC:**	
External:			
○ Social or CPS Case Worker Name/			
○ Probation Officer Name/Phone:			
○ Parent/Guardian Name/Phone:	**Youth Language**	**LAR Language Spoken**	
○ MH Professional Name/Phone:			
○ Law Enforcement Name/Rep/Phone:			
○ School Staff/District Rep/Phone:			
○ Household member Name/Phone:			

Youth Behavioral Characteristics	
☐ Violent/physically aggressive behavior	☐ Vandalism
☐ Verbally aggressive or threatening behavior	☐ Drug-related offending
☐ Robbery, theft	☐ Attendance Issues/Truancy
☐ Selling substances	☐ Expelled, dropped out, withdrew
☐ Non-compliance with family rules	☐ Multiple school sanctions i.e. suspension
☐ Sexual offenses with other anti-social behavior	☐ Engages, spends time with other antisocial peers
☐ Substance use	☐ Poor relationships with school staff
☐ Poor relationships with those with authority	☐ Lack of prosocial peers
☐ Violation with probation or court order	☐ Low or poor Academic performance/engagement
☐ Running away	

Other:

Desired Outcomes for Referral to MST Please rate each of the following based on priority (H – High; M – Medium; L – Low)
Prevent out of home placement
Improve family problem solving skills
Reduce aggressive and/or criminal behaviors
Improve family communication and cohesiveness
Retain in school/vocational efforts and/or improve school attendance
Improve youth pro-social involvement and peer relationships
Improve academic functioning
Improve family behavioral management skills

PROGRAM EXCLUSIONS:

- Youth living independently
- Youth with moderate to severe autism (I.e. difficulties with social communication, social interaction, and repetitive behaviors
- Youth who are actively homicidal, suicidal, or psychotic
- Youth whose psychiatric problems are primary reason leading to referral, or who have severe and serious psychiatric problems
- Juvenile sex offenders (I.e. sex offending in the absence of other delinquent or antisocial behavior)
- Youth for whom an intellectual disability is the only influence or direct contributor to the youth's referral behaviors (I.e. this would include youth who are severely or profoundly intellectually impaired or with a moderate, severe, or profound intellectual development)

Referral currently receiving Betty Hardwick Services? Select one of the following

☐ **Yes, BHC No.:** ☐ **No** ☐ **Unknown**

Has family been informed about MST Services Referral? Select one of the following

Yes ☐ **No** ☐

Is there an active or open CPS case with the family? Yes ☐ **No** ☐

Please attach the following in your referral packet if available:

- Summary of Prior Offending
- Recent Mental health Evaluation
- Recent Educational Evaluation

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

- ☐ Accepted for MST Program
- ☐ Not Accepted/Inappropriate for MST Program:

Further Information or Inquiries:

Laura Taff MA, LPCS
MST Supervisor
ltaff@bettyhardwick.org
Office: 325-690-5109
Fax: 325-690-5253
MST Email: MST@bettyhardwick.org

Please Send Referrals to:
MST@bettyhardwick.org