

**MULTIDIMENSIONAL FAMILY THERAPY (MDFT) &
MULTIDIMENSIONAL FAMILY THERAPY OPIOID USE
DISORDER (MDFT OUD) REFERRAL FORM**

MDFT is a family centered, community based treatment for youth struggling with mental health, complex clinical (including substance use and other issues), social and educational challenges. MDFT intervenes in 4 related areas: youth, parents, family and community. It includes individual therapy for youth, parent education and support, family therapy and community interventions and collaborations. From a foundation of improved family relationships, MDFT emphasizes behavioral change in the natural environment and uses interventions to promote the parent's capacity to monitor and interact positively with their youth. To make a referral, please email or fax this form to the provider in your area along with a release of information.

Community Health Resources: (Hartford, Manchester, Enfield) (e) MDFTReferral@chrhealth.org (f) 860-697-3406
 Boys & Girls Village (Bridgeport, Norwalk, Stamford) (f) 203-330-6756
 Child and Family Agency of Southeastern Connecticut (Middletown, Norwich, Willimantic) (f) 860-661-4262
 Connecticut Junior Republic (Waterbury, Danbury, Torrington) (p) 203-558-9665 (f) 203-759-1224
 Community Mental Health Affiliates (New Britain, Meriden) (f) 860-224-6516 (p) 860-229-4830
 United Community & Family Services (Middletown, Norwich, Willimantic) (e) cpalma@ucfs.org
 Wheeler Clinic (Greater New Haven) (e) MDFTNewHaven@wheelerclinic.org
 Wheeler Clinic (Waterbury, Danbury, Torrington) (e) MDFTWaterburyTorringtonDanbury@wheelerclinic.org
 Wheeler Clinic (New Britain, Meriden) (e) MDFTNewBritainATM@wheelerclinic.org

MDFT OUD provides weekly in-home family-focused treatment for youth up to 21 years old with opioid use problems. MDFT OUD combines three services: Multidimensional Family Therapy (MDFT), Medication Assisted Treatment (MAT), and Recovery Management Checkups and Recovery Monitoring and Support (RMS) to reduce opioid use and commonly associated substance use problems, and offers up to 12 months of support after treatment ends. MDFT is an intensive, family-centered treatment for youth with substance use and co-occurring mental health problems.

Youth:

Referral Date:

First name:	Last name:	Date of birth:
Age:	Race/ethnicity:	Email:
Address:		Cell phone:
Youth resides with:		Relationship:
School:	Grade:	Primary language:

Caregiver/Guardian:

Caregiver name:	Last name:	Primary language:
Phone number:	Email:	Cell phone:
Address:		
Legal guardian's name:	Last name:	Primary language:
Phone number:	Cell phone:	Email:
Address:		
Legal guardian's name:	Last name:	Primary language:
Phone number:	Cell phone:	Email:
Address:		

Is the youth currently on probation or court/JRB involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Is the youth currently DCF involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Youth Concerns

Has the youth experienced any of these challenges in the last 90 days? Check all that apply.

Substance use:

List Substances:

Family Conflict

Anxiety (e.g., excessive worry or fear, social anxiety, panic attacks)

Depression (e.g., irritability, loss of interest in things, sad affect)

Verbal aggression

Physical aggression

Homicidal Ideation

Suicidal Ideation

Delinquent/Conduct/Oppositional Behaviors

School Problems (Truancy, behavior, performance)

Violence

Impulsivity

Emotional dysregulation

Trauma

Runaway/AWOL behaviors

Housing instability / homelessness

Has the youth ever experienced any of the following? Check all that apply

Suicide attempt

Comment:

Psychiatric Hospitalization

Comment:

Episode(s) of psychosis or psychotic symptoms

Comment:

Suspected Sex Trafficking

Comment:

Trauma

Comment:

Drug or alcohol overdose

Comment:

Drug rehabilitation / Detox

Comment:

Removal from the home due to child maltreatment

Comment:

Living in congregate care / out of home placement

Comment:

Other:

Diagnosis, if known:

Is the family; willing to accept treatment somewhat resistant, or resistant to treatment?

Identified supports/strengths (family, friends, faith, community etc.)

List other pending referrals:

List current providers:

Reason for referral and other important information:

Form Completed By:

First name:	Last name:	Email:
Agency (if applicable):	Title at agency:	Phone number:
Supervisor's name (if applicable):	Supervisor phone:	