**Functional Family Therapy Referral From**

Instructions: Please fill out this form and attach a signed and witnessed RELEASE OF INFORMATION authorizing case relevant information to be shared between agency staff and staff from Creative Solutions Counseling

Send email securely to:

[MFTSOLUTIONS@COMCAST.NET](mailto:MFTSOLUTIONS@COMCAST.NET)

Or Call:

360-701-7820

|  |  |
| --- | --- |
| Date: | Clinician/Referent: |
| **Medicaid #** | Phone #: |
| **Client Information:** | |
| Name: | Date of Birth: |
| Address:  Case Number: | Phone Number:  Cell Phone:  Email: |
|  | |
| Reason for FFT referral: | |
| Treatment/behavioral objectives: | |
| **Family** | |
| Please list current makeup of household, relationship to client, ages and any special problems/concerns: | |
| **Background Material** | |
| Attach any pertinent case information such as a pre-sentence report, psychological evaluation, risk assessment, etc. | |