**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

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. |