

**Attention:** Atia Wise, FCT Supervisor

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**Family Centered Treatment (FCT) Referral Form**

Referral Source:

Contact information:

Name:

DOB:

SSN:

Medicaid #:

Address:

Guardian / Parent / Responsible Party Name:

Contact Phone Number:

Okay to identify caller as SouthLight FCT? YES / NO

Okay to leave a message? YES / NO

Are there any weapons in the home? YES / NO

Are there any animals in the home? YES / NO

Reason for referral: (Please provided a brief social history of events that prompted referral)

**Please check all that apply**

* Mental Health Diagnosis
* Significant Family Functioning Issues: Communication; Role Performance; Behavior Control; Inappropriate expression of emotions; Lack of involvement with family and/or peers
* A Step-down from a higher level of care: Residential Facility
* DSS involvement within the last year
* Juvenile Justice Involvement in the last 6mo.
* Behavioral Health ER visit and/or hospitalization in last 6mo.
* Multiple school suspensions
* Crisis intervention in last 6mo. (not exclusive of) law enforcement involvement, crisis line calls, mobile crisis service, emergency crisis bed stay
* Victim of Trauma
	+ Abuse victim (physical, verbal, sexual)
	+ Neglect victim (physical, emotional)
	+ Parent/Caretaker that is a victim of Domestic Violence
	+ Parent/Caretaker that abuses substances/alcohol
	+ Parent/Caretaker with mental health diagnosis
	+ Loss of a parent/caretaker to divorce, abandonment, or death
	+ Parent/Caretaker incarceration
	+ Surviving or recovering from an accident
	+ Homelessness
* Risk of removal (Out of home placement): Youth Detention Center; Residential Treatment Center
* Transitioning home: Adoption, Foster Home, Living with relatives