

Referral Form – Integrated Family Therapy (IFT)

Referral Date:	Youth Name:
Date of Birth:	Primary Phone #:
School:	Home Address:
ICC Screening Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
Key Participants	Name, Phone, Email
<input type="checkbox"/> Referral Source	
<input type="checkbox"/> Parent/Guardian/Caregiver	
<input type="checkbox"/> Household Member Names	
<input type="checkbox"/> Mental Health Worker	
<input type="checkbox"/> Social Services/Case Worker	
Reasons for Referral	
DSM-5/ICD-10 Diagnosis:	
Desired Outcomes	

Please attach the following and indicate all that are available:

Recent Mental Health Evaluation

Recent Educational Evaluation

Recent ICC Evaluation

Send To:
<p>Daphne Pleasant, LMFT Director of Family Therapy Services d.pleasant@embrace-mh.org 925.876.2325 (phone) 925.943.6091 (fax)</p>