Embrace
mental health

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Referral Form – Integrated Family Therapy (IFT)

Referral Date:	Youth Name:
Date of Birth:	Primary Phone #:
Birth County:	Mother's Maiden Name:
School:	Home Address:
MediCAL Coverage: ☐ Yes ☐ No	MediCAL ID#:
ICC Screening Completed: ☐ Yes ☐ No	Preferred Language for Services: ☐ English ☐ Spanish ☐ Other:
Key Participants	Name, Phone, Email
☐ Referral Source	
☐ Parent/Guardian/Caregiver	
☐ Household Member Names	
☐ Mental Health Worker	
☐ Social Services/Case Worker	
Reasons for Referral	
DSM-5/ICD-10 Diagnosis:	
Desired Outcomes	
Desired Location/Mode of Service (choose one or more)	
☐ In person at: ☐ Home ☐ Other location:	☐ Telehealth (via Zoom video conferencing)

Please attach the following and indicate all that are available:

☐ Recent Mental Health Evaluation ☐ Recent Educational Evaluation ☐ Recent ICC Evaluation

Send To:
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