



Los Angeles County Department of Mental Health Functional Family Therapy (FFT) Referral Form

Functional Family Therapy (FFT) is an intense short-term evidence-based family intervention for youth ages 11-18 with behavioral and emotional challenges. FFT focuses on improving family communication, strengthening relationships and reducing maladaptive behaviors.

Referral Date		
Date:		
Client Information		
Client Name:	DOB:	IBHIS #:
Medi-Cal #:	Phone:	Preferred Language:
Address:	City:	Zip Code:
Referring Provider Information		
Provider Name and Provider #:		Referring Practitioner/Title:
Phone:		Email:
Parent/Guardian/Caregiver		
Name:	Phone:	Preferred Language:
☐ Family is aware of referral		
Check if applicable		
☐ Current DCFS involvement (open case)	☐ Probation	
☐ Foster Care Placement		
Reason for Referral (check all that apply)		
☐ Aggressive and/or bullying behaviors ☐ Argumentative ☐ Chronic school avoidance/Truancy ☐ Defiance ☐ Destruction or damage of property ☐ Difficulty regulating emotions ☐ Intentional disruptive behaviors ☐ Manipulative or deceitful behaviors	☐ Noncompliance with rules ☐ Runaway ☐ Shoplifting/Theft ☐ Substance use or substance related concerns ☐ Violent/ Fights/ Physically aggressive behaviors ☐ High Risk Group ☐ Other: _____	

**Additional Criteria**

- ☐ Client is between 11-18 yrs of age
- ☐ Client/Caregiver willing to participate in 12-16 sessions over 3-5 months
- ☐ Client identified collateral support who is willing to participate in weekly family meetings in person and by phone

Additional Referral Information (i.e. special accommodation/accessibility needs, etc.)**Please submit the following attachments with your referral**

- ☐ Most recent clinical assessment/ Addendum

Exclusion Criteria

- *Active SI/HI*
- *Imminent serious youth or severe family safety concerns*
- *Psychosis*
- *Severe substance use*
- *Non-verbal or serious barriers to verbal communication*
- *Presenting with current sexual offences*

For general questions, please contact BHSAEI@dmh.lacounty.gov