

**BSFT REFERRAL/APPLICATION**

NORTH DAKOTA DEPARTMENT OF CORRECTIONS AND REHABILITATION  
 BRIEF STRATEGIC FAMILY THERAPY (BSFT)  
 SFN 62169 (03-2023)

Date	BSFT/JID Number	Family Name
------	-----------------	-------------

**REFERRING AGENCY INFORMATION**

Name of Referring Worker	Work Cell Phone Number	Email Address
Name of Agency		Office Telephone Number
Agency Address	City/State	ZIP Code

**REASON FOR REFERRAL** (Without the therapeutic intervention of Brief Strategic Family Therapy, youth is at risk of being removed from the family)

Referral Court Ordered <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Notified of Referral <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk of Placement <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Attitude Towards Service <input type="checkbox"/> Yes <input type="checkbox"/> No

**REFERRED JUVENILE INFORMATION**

Last Name	First Name	Middle Name/Initial
Date of Birth	Race	Ethnicity

**CUSTODY INFORMATION**

Name/Agency	Type <input type="checkbox"/> Physical <input type="checkbox"/> Legal <input type="checkbox"/> Both
Name/Agency	Type <input type="checkbox"/> Physical <input type="checkbox"/> Legal <input type="checkbox"/> Both
Name/Agency	Type <input type="checkbox"/> Physical <input type="checkbox"/> Legal <input type="checkbox"/> Both
Current Probation/Custody Term Dates	

**LEGAL HISTORY**

Date	Offense	Outcome/Orders

**SCHOOL INFORMATION**

Name of School Facility	Last Grade Completed
School Concerns <input type="checkbox"/> Truancy <input type="checkbox"/> Grades <input type="checkbox"/> Conflict with Staff <input type="checkbox"/> Peer Relationships <input type="checkbox"/> Lack of Involvement <input type="checkbox"/> Assessment Needed <input type="checkbox"/> On an Individual Education Plan (I.E.P.) <input type="checkbox"/> Other	

**PLACEMENT HISTORY**

Facility/Agency Name	Dates of Placement	Successful Discharge
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Contact Person (if Juvenile is in placement)	Telephone Number	Email

**MEDICATION INFORMATION**

Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> ADHD	<input type="checkbox"/> Unknown/Don't Know
<input type="checkbox"/> Depression	<input type="checkbox"/> Other
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other
<input type="checkbox"/> Bi-Polar	
Comments/Concerns	

**FAMILY INFORMATION**

Home Address	City/State	ZIP Code
Directions to Home (if rural)		
Telephone Number	Name	Type (home, cell, work)

**FAMILY MEMBERS**

Name	Date of Birth	Relationship to Juvenile	Occupation
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Parent Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
---

**FAMILY ISSUES CHECKLIST (check all that apply)**

Family Issues	*Family Member/Comment	Family Issues	*Family Member/Comment
<input type="checkbox"/> Abuse – Physical		<input type="checkbox"/> Learning Disabled	
<input type="checkbox"/> Investigated		<input type="checkbox"/> Parent/Child Conflict	
<input type="checkbox"/> Abuse - Sexual		<input type="checkbox"/> Sibling Conflict	
<input type="checkbox"/> Investigated		<input type="checkbox"/> Fighting at home	
<input type="checkbox"/> Medical Issues		<input type="checkbox"/> Fighting out of home	
<input type="checkbox"/> Parental Supervision		<input type="checkbox"/> Divorce	
<input type="checkbox"/> Housing		<input type="checkbox"/> Separation/Marital	
<input type="checkbox"/> Financial		<input type="checkbox"/> Sexual Dysfunction	
<input type="checkbox"/> Food/Nutrition		<input type="checkbox"/> Blended Family	
<input type="checkbox"/> Employment		<input type="checkbox"/> Imprisonment	
<input type="checkbox"/> Truancy		<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Delinquency/Behavior		<input type="checkbox"/> Borderline Intelligence	
<input type="checkbox"/> Runaway		<input type="checkbox"/> Emotionally Disturbed	
<input type="checkbox"/> Alcohol		<input type="checkbox"/> Other	
<input type="checkbox"/> Drugs/Narcotics		<input type="checkbox"/> Other	

\*Please identify family member that the concern applies to or provide any additional comments after each checked concern.

**FAMILY SERVICE HISTORY (current and previous service activity)**

Family Member	Provider/Agency	Contact Person	Service	Dates of Service	Outcome

**FAMILY STRENGTHS (check all that apply)**

<input type="checkbox"/> open to counseling services	<input type="checkbox"/> communicates and listens
<input type="checkbox"/> fosters table time and conversation	<input type="checkbox"/> sense of trust
<input type="checkbox"/> affirms and supports one another	<input type="checkbox"/> sense of play and humor
<input type="checkbox"/> balance of interaction among members	<input type="checkbox"/> shares leisure time
<input type="checkbox"/> exhibits a sense of shared responsibility	<input type="checkbox"/> teaches respect for others
<input type="checkbox"/> teaches a sense of right and wrong	<input type="checkbox"/> respects the privacy of one another
<input type="checkbox"/> has a shared religious/spirituality core	<input type="checkbox"/> values service to others
<input type="checkbox"/> admits to and seeks help with problems	<input type="checkbox"/> Other
<input type="checkbox"/> has a strong sense of family in which rituals and traditions abound	

**REFERRED JUVENILES STRENGTHS (check all that apply)**

<input type="checkbox"/> enjoys new experiences	<input type="checkbox"/> cares for belongings
<input type="checkbox"/> pride in cultural heritage	<input type="checkbox"/> follows rules
<input type="checkbox"/> has employment	<input type="checkbox"/> resilient/tolerates change
<input type="checkbox"/> manages money well	<input type="checkbox"/> sense of humor
<input type="checkbox"/> does well in school	<input type="checkbox"/> good sense of self
<input type="checkbox"/> creative, artistic, musical	<input type="checkbox"/> insightful
<input type="checkbox"/> involved in community/school activities	<input type="checkbox"/> friendly/outgoing
<input type="checkbox"/> well-groomed/takes pride in appearance	<input type="checkbox"/> good peer group
<input type="checkbox"/> hopeful/positive	<input type="checkbox"/> clean and sober

Other Comments/Concerns/Information

**DISCLAIMER:**

We strongly advise NO other competing therapies be engaged with the family or Identified Patient while Brief Strategic Family Therapy is provided. All other therapies should be placed on hold until Brief Strategic Family Therapy service is completed.