BSFT REFERRAL/APPLICATION

NORTH DAKOTA DEPARTMENT OF CORRECTIONS AND REHABILITATION
BRIEF STRATEGIC FAMILY THERAPY (BSFT)
SFN 62169 (04-2025)

Application/Referral Date	BSFT/JID Number	Family Name

REFERRING AGENCY INFORMATION

Name of Referring Individual	Agency Name		
Work Cell Phone Number	Office Telephone Number	Office Email Address	
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.)

Court-Ordered Referral	Family Notified of Referral	Risk of Placement
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

RESIDENTIAL/OUT-OF-HOME PLACEMENT REFERRAL

Has a referral been made for residential/out-of-home placement?	☐ Yes *	☐ No	* If "yes," referral date:
Is placement pending?	☐ Yes *	☐ No	* If "yes," projected date:

REFERRED JUVENILE INFORMATION

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

CUSTODY INFORMATION

Name/Agency	Custody Type ☐ Physical ☐ Legal ☐ Both
Name/Agency	Custody Type ☐ Physical ☐ Legal ☐ Both
Name/Agency	Custody Type ☐ Physical ☐ Legal ☐ Both
Current Probation/Custody Term Dates	

LEGAL HISTORY

Date	Offense	Outcome/Orders

SCHOOL INFORMATION

Name of School Facility	Last Grade Completed

School Concerns

- ☐ Truancy
- ☐ Conflict with Staff
- ☐ Lack of Involvement
- ☐ On an Individual Education Plan (I.E.P.)
- ☐ Grades
- ☐ Peer Relationships
- ☐ Assessment Needed
- ☐ Other (please specify) _____

Comments

PLACEMENT HISTORY

Facility/Agency Name	Dates of Placement	Successful Discharge
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ **Yes** ☐ **No**
Contact Person Name (if juvenile is in placement)	Contact Phone Number	Contact Email Address

MEDICATION INFORMATION

Medication
☐ Yes* ☐ No * If "yes," please include medication names/dosages in Comments/Concerns field below.

Comments/Concerns

FAMILY INFORMATION

Home Address (Physical Address)	City	State and ZIP Code

Directions to Home (if rural)

	Name	Date of Birth	Relationship to Juvenile	Occupation	Telephone Number	Phone Type
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Mother's Current Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Father's Current Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

FAMILY SERVICE HISTORY (current and previous service activity)

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

FAMILY ISSUES CHECKLIST (check all that apply)

Family Issues	*Family Member and/or Comment	Family Issues	*Family Member and/or Comment
☐ Abuse - Physical		☐ Disabilities	
☐ Investigated		☐ Parent/Child Conflict	
☐ Abuse - Sexual		☐ Sibling Conflict	
☐ Investigated		☐ Fighting at home	
☐ Medical Issues		☐ Fighting out of home	
☐ Parental Supervision		☐ Divorce	
☐ Housing		☐ Separation/Marital	
☐ Financial		☐ Problematic Sexual Behavior	
☐ Food/Nutrition		☐ Blended family	
☐ Employment		☐ Incarceration	
☐ Truancy		☐ Mental Health Concerns	
☐ Delinquency/Behavior		☐ Self-harm/Suicidal Ideation	
☐ Runaway		☐ Other	
☐ Alcohol		☐ Other	
☐ Drugs/Narcotics		☐ Other	

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

OTHER COMMENTS/CONCERNS/INFORMATION

SIGNATURE

Referring Agency Representative Signature	Date

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.