

## **Charlestown Family Support Circle Referral form**

**“Our mission is to provide supportive services to Charlestown youths and families who are at risk or in need of support, to ensure all Charlestown youths are able to develop and grow to reach their full potential”.**

### **What we do?**

CFSC assists Charlestown youths and families by connecting them to resources and supports in their community. We provide short term counseling, case management and care coordination services to residents of Charlestown in an effort to support families and increase access to services.

The FSC Clinician will work closely with families to help them identify their strengths, needs, and goals to make changes within their lives. Families are linked to appropriate referrals, community services, and natural supports.

### **Who can refer a youth and family to the Charlestown Family Support Circle?**

Anyone involved in the youth’s life is able to submit a referral on behalf of the youth and/or family. Below is a list of the most common referral sources:

- Community providers and social service agencies
- Law enforcement, Department of Children and Families and probations
- School principals, teachers and school social workers
- Community social workers
- Coaches, neighbors and community members
- Families (Self-referral)

### **Who is eligible for the program?**

- Charlestown Resident
- Child or youth between the ages of 7-18 years old
- A parent in need of supportive services and as a result this, would benefit the youth or children living in the home
- Youth struggling at school, home or in the community

If you would like to refer a youth to the Charlestown Family Support Circle please complete the attached forms and fax to:

**The Charlestown Family Support Circle  
Attention: Phenice Zawatsky, LICSW Charlestown Family Support  
Clinician  
Fax number: 617-726-6624**

For additional questions contact Phenice Zawatsky at 617-726-0058

**Charlestown Family Support Circle  
Referral form**

<b>Date of referral:</b>
<b>Does youth live in Charlestown?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is the family aware that they have been referred to the Charlestown Family Support Circle?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Client information:</b>
Client Name/ DOB/Gender:
Address:
Phone number (Home)/ Mobile number:
School Name/Address/Zip code:
Insurance name/ID number (Youth):
Youth lives with: <input type="checkbox"/> Parent: <input type="checkbox"/> Guardian: <input type="checkbox"/> Other:
Is youth in DCF custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mother (include name, address, phone):
Father (include name, address, phone):
Siblings (include name, age):
Guardian name/Custodial Adult (include name, address, phone):
Relationship to the youth:
Youth's Race and Ethnicity:
Language(s) spoken at home:
Is translation needed for the family?

<b>Please check all that apply to Client and/or Family:</b>
<input type="checkbox"/> Access to health care <input type="checkbox"/> Communication issues <input type="checkbox"/> Crisis management <input type="checkbox"/> DCF involvement
<input type="checkbox"/> Domestic violence <input type="checkbox"/> Education <input type="checkbox"/> Extracurricular activities <input type="checkbox"/> Family conflict <input type="checkbox"/> Finances <input type="checkbox"/> Mental Health
<input type="checkbox"/> Probation/Criminal Court/Child Requiring Assistance <input type="checkbox"/> Legal support/involvement <input type="checkbox"/> Social Support
<input type="checkbox"/> Substance Use <input type="checkbox"/> Transportation <input type="checkbox"/> Self care <input type="checkbox"/> Other
<input type="checkbox"/> Need assistance accessing resources to meet basic needs (food, housing, clothing, etc...)
<input type="checkbox"/> Difficulty functioning at home, school or in the community
<input type="checkbox"/> History or exposure to substance abuse, domestic violence, and/or community violence
<input type="checkbox"/> Involved in multiple services or multiple systems (probation, mental health, family court, DCF, etc.)
<input type="checkbox"/> Enrolled in services that have not been helpful to youth
<input type="checkbox"/> Serious Emotional Disturbance or behavioral disorder
<input type="checkbox"/> Experienced one of the following in the last 30 days:
<input type="checkbox"/> Serious suicidal symptoms or other life threatening destructive behaviors
<input type="checkbox"/> Significant psychotic symptoms
<input type="checkbox"/> Behavioral problems causing a risk or personal injury or significant property damage
<input type="checkbox"/> Behavioral Symptoms:
<input type="checkbox"/> Phobias <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicidal ideation or attempt <input type="checkbox"/> Aggression
<input type="checkbox"/> Property Destruction <input type="checkbox"/> Cruelty to animals <input type="checkbox"/> Fire setting <input type="checkbox"/> Self Harm
<input type="checkbox"/> Sleeping problems <input type="checkbox"/> Bed wetting <input type="checkbox"/> Developmental delays <input type="checkbox"/> Anger
<input type="checkbox"/> Physical complaints <input type="checkbox"/> Inappropriate sexual behavior <input type="checkbox"/> Other

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<b>Reason for referral</b> (Provide brief description of behavior and/or family circumstances):
<b>Family Goals</b> (Describe outcomes the family hopes to achieve):
<b>Family Strengths:</b>
Youth:
Family:
<b>Present and/or past services involved with the family:</b> (DCF, ICC, probation, individual therapy, IHT, mentor program, etc.). Please include name, address, contact phone number and email):
<b>Does the child have an IEP, 504 plan or any special education accommodations?</b>
<b>Past/current diagnosis:</b>
<b>Does youth take medication as prescribed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
List medications (if applicable):
<b>Additional information:</b>
<b>Referral source:</b>
Name/ Phone Number:
Agency/Address: