**Locked Out Referral Form**

---

Date: _______________

Person referring: ______________________________ Contact no:________________

Organisation/Agency referring: _________________ E-Mail: ___________________________

## Please ensure family is aware of referral and willing to attend therapy

**Referred Family Composition:**

| Name | Date of birth | Occupation/School |
|---|---|---|
| ___________________________ | ___/____/____ | ___________________ |
| ___________________________ | ___/____/____ | ___________________ |
| ___________________________ | ___/____/____ | ___________________ |
| ___________________________ | ___/____/____ | ___________________ |
| ___________________________ | ___/____/____ | ___________________ |
| ___________________________ | ___/____/____ | ___________________ |
| ___________________________ | ___/____/____ | ___________________ |

Do the above live in the same household?

_________________________________________________________________________________

_________________________________________________________________________________

---

**Address:**

Family Contact Numbers: __________________ belonging to: ____________________

---

**How would family therapy be helpful to this family?**

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

**Sentenced** ◯ **Arrested** ◯ **Estimate Date of Release:** ___________________

**Nature of Primary Crime:**

**_______________________________________________________a**

**Risks Identified**

- [ ] No apparent risks to physical safety.
- [ ] Physical abuse; members involved ________________________________________
- [ ] Emotional abuse; members involved ________________________________________
- [ ] Suicidal ideation/attempts ________________________________________
- [ ] Past history of threats or violence towards professionals; members involved:

  ________________________________________________________________________

  ________________________________________________________________________
- [ ] Past/present Alcohol or drug abuse? Yes ☐ No ☐
- [ ] Health issues/medication: _________________________________________________

Other info:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

---

*Thank you for taking the time to fill in this form. Please feel free to contact us with any queries you might have on 77778001 or email [info@ift-malta.com](mailto:info@ift-malta.com) or [info.mddmalta@gmail.com](mailto:info.mddmalta@gmail.com)*