Referral for Therapeutic Behavioral Services

TBS
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Referring Party

Name: _____ Tel.#: _____ Ext Fax #: _____

Business address: _____

Relationship to client: _____ E-Mail: _____ Referral Date: _____

Mental Health Services

Clinician: _____ Tel.# _____ Ext. Fax. #: _____

Agency _____ Rpt Unit: _____ E-Mail _____

Biographical Data

Client Name: _____ Age: _____ DOB: _____ Gender ☐M ☐F

Social Security Number: _____ Medi-Cal Number: _____ MIS#: _____

Ethnicity: ☐ African/American ☐ Asian/American/Pacific Islander ☐ Bi-Racial _____
☐ Hispanic ☐ Native American ☐ Caucasian ☐ Other: _____

Primary Residence

☐ Bio Family Hm ☐ Foster Hm ☐CommunityG rpHm/RCL _____ Residential/RCL _____ ☐Other _____

Caregiver: _____ Legal Guardian: _____

Current Address: _____ City, State, Zip: _____

Tel.#: _____ Alt.Tel.# _____ Primary Language Spoken in the Home: _____

At placement since: _____ Total # of placements: _____

School Information

Name of School: _____ Tel.# _____ ☐IEP ☐NPS

Address: _____ **District**: _____ Grade: _____

Social Service/Attorney information

CSW
Name: _____ Phone: _____

Notified of Referral: ☐Yes ☐NO Fax: _____

Minor's Attorney

Name: _____ Phone: _____

Notified of Referral: ☐Yes ☐NO Fax: _____

Probation Officer:

Name: _____ Phone: _____

Notified of Referral: ☐Yes ☐NO Fax: _____

Requested TBS Schedule

School ☐ Home ☐

Monday _____ Thursday _____ Sunday _____

Tuesday _____ Friday _____

Wednesday _____ Saturday _____

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Purpose of Referral

(Please check One)
- ☐ To prevent psychiatric hospitalization
- ☐ To prevent placement in a higher level of care
- ☐ To enable transition to a lower level of care
- ☐ Current placement is in jeopardy

Certified Class Membership (Check all that apply)

- ☐ In RCL 12 or above
- ☐ Being considered for RCL 12 or above
- ☐ Psychiatric Hospitalization in preceding 24 months*
- ☐ At Risk of being hospitalized.
- ☐ Previously received TBS while class member

Dates _____ Agency _____

*If hospitalized in past 24 months, how many times? _____

Dates of most recent hospitalization: _____

I hereby certify that the child/youth is a member of the Certified Class for TBS.

Signature of LPHA: _____ Date: _____

Current Diagnoses

Axis 1 P / S _____ Code _____

Axis 1 P / S _____ Code _____

Axis II _____

Axis III _____ Axis IV (check as many as apply)

- ☐ Primary Support Group
- ☐ Social Environment
- ☐ Educational
- ☐ Occupational
- ☐ Housing
- ☐ Economic
- ☐ Access to Healthcare
- ☐ Interaction w/Legal System
- ☐ Other Psychological / Environmental

Axis V Current GAF _____

Medication

Is client currently prescribed medication? ☐ Yes ☐ No

Is client compliant with taking meds? ☐ Yes ☐ No

Medications/ dosage: _____

Clinical information: Special Risks and Concerns

- ☐ Sleep Problems
- ☐ Weapon Use
- ☐ Aggressive to younger Children
- ☐ Truancy
- ☐ Arrest Record
- ☐ Suicidal Attempts
- ☐ Encopretic
- ☐ Enuretic
- ☐ Fire Setting
- ☐ Homicidal Ideation
- ☐ Poor Impulsive Control
- ☐ Suicidal Ideation
- ☐ Animal Cruelty
- ☐ School Problem
- ☐ Sexual Acting Out
- ☐ AWOL
- ☐ Self Abusive Behavior
- ☐ Psychosis
- ☐ Sexual Abuse History

Medical Problems
☐ NO ☐ Yes ☐ Unknown

Medically Cleared
☐ NO ☐ Yes ☐ Unknown

Physical Disabilities or limitations
☐ NO ☐ Yes ☐ Unknown

Developmentally Disabled
☐ NO ☐ Yes ☐ Unknown

Regional Center Involvement
☐ NO ☐ Yes ☐ Unknown

Substance Abuse /Smoking
☐ NO ☐ YES ☐ Unknown if yes, type of substance last used?

Please check that the client has the following current documents:

- ☐ **DMH Client Care / Coordination Plan** *or other Service Plan / Treatment Goals if non-DMH agency*
- ☐ **DMH Initial Assessment (9 Page)** *or other assessments if non- DMH agency*
- ☐ **DMH Payer Financial information & Addendum**
- ☐ **Acknowledgement of Privacy Practices**

Comments:

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Check appropriate functional unit(s) that apply to benchmark behavior:

☐ Physical Aggression:

☐ Throwing objects ☐ Hitting ☐ Kicking ☐ Spitting ☐ Chocking Others ☐ Pushing
☐ Property destruction ☐ Self-injurious behavior ☐ Biting ☐ Slapping ☐ Dangerous behaviors
☐ Posturing/threatening gestures ☐ Other: _____

Frequency: _____ Per ☐ day ☐ week **Level of behavior:** ☐ Mild ☐ Moderate ☐ Severe
Location: ☐ Home ☐ School ☐ Community

☐ Verbal aggression:

☐ Profanity/cursing Tantrums ☐ Yelling Screaming ☐ Crying ☐ Provoking others
☐ Explosive verbal outburst ☐ Threats of harm ☐ Intimidating voice

Frequency: _____ Per ☐ day ☐ week **Level of behavior:** ☐ Mild ☐ Moderate ☐ Severe
Location: ☐ Home ☐ School ☐ Community

☐ Oppositional Behavior:

☐ Refusing to remain in safe designated area ☐ School refusal ☐ Medication refusal
☐ Refusal to follow or complete AM/PM routine ☐ Refusal to follow reasonable adult request
☐ Other: _____

Frequency: _____ Per ☐ day ☐ week **Level of behavior:** ☐ Mild ☐ Moderate ☐ Severe
Location: ☐ Home ☐ School ☐ Community

☐ Other Crisis Behavior:

☐ Cutting ☐ Ingesting harmful substances ☐ Head banging ☐ Other: _____
Frequency: _____ Per ☐ day ☐ week **Level of behavior:** ☐ Mild ☐ Moderate ☐ Severe
Location: ☐ Home ☐ School ☐ Community

OTHER SERVICES OR RESOURCES TRIED OR CONSIDERED:

When TBS is not available, what services are <u>usually</u> used for these types of problems?
Check all that apply: ☐ Individual therapy, ☐ group therapy, ☐ family therapy, ☐ 1:1 residential services, ☐ school aid, ☐ medications ☐ hospitalization,

Which of these services have been attempted? (*Note for <u>how many hours</u> per week*)

What were the results of the services?

If the Services were not used, why?

What other steps have been taken to date?

In your judgment, what will be the result if TBS is not successful?

Client Functional Strengths / Motivation:

Barriers to change (symptoms, situation, history, etc.): _____

Interventions and Outcomes List (on separate sheet if necessary) all previous interventions used and the client's response: _____

Signature of referring person:	**Date:**

This section to be filled out by OFFICE ONLY

ACTION: Approved_____ Referred for Other Services_____