**\*Please complete all items and include TBS referral form, current assessment, and court order if applicable.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Child’s Name: | | |  | | | | | | | | | | | | | | | | | | Preferred Name: | | | | | | | | | | | | | SSN: | | | | | | |
| Date of Birth: | | |  | | | | | | | | Age: | |  | | | | | | | | | Preferred Gender: | | | | | | |  | | | | | | | | | | | |
| Primary Caregiver: | | |  | | | | | | | | | | | | | | | | | | | Phone: | | | | | | | |  | | | | | | | | | | |
| Relationship: | | | Bio  Foster  Guardian | | | | | | | | | | | Adoptive | | | | | | | | | | | Presumptive Transfer YES  NO | | | | | | | | | | | | | | | |
| Accurate Address: | | |  | | | | | | | | | | | City: | | | | |  | | | | | | | | | | | | | Zip: | | | | | | |  | |
| Ethnicity: | |  | | | Caregiver’s Preferred Language: | | | | | | | | | | |  | | | | | | | | | | Preferred TBS service time: | | | | | | |  | | | | | | | |
| School: | |  | | | | Grade: | | | |  | | IEP  Yes  No | | | | | | | | | Enrolled  Suspended/Expelled | | | | | | | | | | | | | | | | | | | |
| To have initial 30 days of TBS, must be a “yes” for both #1 and #2 below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Does child have Full Scope Medi-Cal?  Yes  No | | | | | | | | | | | | | | |  | |  | | | | | |  | | | | | | | |  | | | | | | |  | | |
| 2. Is child currently receiving EPSDT services (**E**arly **P**eriodic **S**creening, **D**iagnosis & **T**reatment services)?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Therapy | Medication | | | Other: | | | | |  | | | | | | | | | | | | | ICD-10/DSM 5 Dx: | | | | | | | | |  | | | | | | | | | |
| **THERAPIST** | | | | | | | **COUNTY SOCIALWORKER** | | | | | | | | | | | | | | | | | **PROBATION OFFICER** | | | | | | | | | | | | | | | | |
| Name: | | | | | | | Name: | | | | | | | | | | | | | | | | | Name: | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | Phone: | | | | | | | | | | | | | | | | | Phone: | | | | | | | | | | | | | | | | |
| Email: | | | | | | | Email: | | | | | | | | | | | | | | | | | Email: | | | | | | | | | | | | | | | | |
| 3. Please list current medications and name of MD/psychiatrist: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To meet class for additional TBS beyond the initial 30 days, must meet criteria for at least one of the following: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Is it highly likely that child will be unable to transition to lower level of care? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
| 5. Is child currently placed in or being considered for an STRTP? STRTP Facility: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| 6. Was the child hospitalized or considered for hospitalization in a psychiatric facility during the past 24 months?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of hospital and date:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Without TBS is it highly likely that the child will require higher level of care?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Has the child previously received TBS? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| CURRENT PROBLEM BEHAVIORS that are jeopardizing placement or transition based on medical necessity. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Self injurious behavior | | | | | | | | Property damage | | | | | | | | | |  | | | | Has made allegations of abuse in past | | | | | | | | | | | | | | | | | | |
| Threat to others | | | | | | | | Verbal aggression | | | | | | | | | |  | | | | Explain: | | | | | | | | | | | | | | | | | | |
| Withdrawal, isolates self | | | | | | | | Physical aggression | | | | | | | | | |  | | | |
| Disregard for rules | | | | | | | | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| POSSIBLE AREAS of FOCUS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Increasing coping strategies | | | | | | | | | Decreasing opposition/defiance | | | | | | | | | | | | | | | | | |  | Community integration | | | | | | | | | | | | |
| Increasing social skills | | | | | | | | | Decreasing self-injurious behaviors | | | | | | | | | | | | | | | | | |
| Increasing daily living skills | | | | | | | | | Decreasing property damage | | | | | | | | | | | | | | | | | |  | Other: | | | | | | | | | | | | |
| Increasing school functioning | | | | | | | | | Decreasing verbal/physical aggression | | | | | | | | | | | | | | | | | |
| Sexual behaviors Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Print Name Title; Agency** | | |  | | | | | | | | | | | | | | | | | **Email Address:** | | | | | | | | | | | | | | | | | | | |  |

**PSYCHIATRIST**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Expedite**  **Referral** | **Rational:** |

***\*Incomplete TBS referral packets cannot be processed.*** *Please email all items together to Managed Care at*

*Email:* [*DBHAuthorizations@fresnocountyca.gov*](mailto:DBHAuthorizations@fresnocountyca.gov)*.*

**URS Approver:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_