FRESNO COUNTY MENTAL HEALTH PLAN

(TBS) Therapeutic Behavioral Services REFERRAL Form

***TBS MUST be added to current Treatment Plan *Referral MUST include most current full assessment**

***Please complete all items and include current assessment, CANS, and client plan with TBS authorized.**

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 County Code: _____ Aid Code: _____

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
☐ Threat to others
☐ Withdrawal, isolates self
☐ Disregard for rules
☐ Property damage
☐ Verbal aggression
☐ Physical aggression
☐ Other
☐ Has made allegations of abuse in past
Explain:

POSSIBLE AREAS of FOCUS

☐ Increasing coping strategies
☐ Increasing social skills
☐ Increasing daily living skills
☐ Increasing school functioning
☐ Sexual behaviors Explain:
☐ Decreasing opposition/defiance
☐ Decreasing self-injurious behaviors
☐ Decreasing property damage
☐ Decreasing verbal/physical aggression
☐ Community integration
☐ Other:

Print Name Title; Agency	**Fax Number:**

☐ **Expedite Referral**	**Rational:**

***Incomplete TBS referral packets cannot be processed.** Please fax or email all items together (TBS Referral form, signed copy of clinical assessment, CANS, signed copy of treatment plan that includes the intervention of TBS) to Managed Care at Fax: (559)455-4633 or Email: DBHAuthorizations@fresnocountyca.gov.*

Therapist's Signature _____ **Date** _____