Therapeutic Behavioral Services
PROGRAM REFERRAL FORM

CLIENT INFORMATION

Consumer Name:__________________________ Gender: __________

SSN: _________________ DOB:______________AGE_____________: RACE: ____________

Medical Assistance #___________________________

GUARDIANSHIP
Is the Consumer committed to the Department of Social Services Yes___ No ___

If yes, list DSS workers Name and county:____________________

Phone #________________________

Is this a voluntary placement: Yes___ No ___ Current CPS Involvement: Yes___ No___

Has the family received recent Family Preservation services: Yes___ No___

Guardian Name that will be working with the TBS Aide: _____________________________________

Full Address: ____

Phone: _________________________________ Alternate Phone: _______________________

The consumer is residing in:
☐Private Residence ☐Group Home ☐Foster/Treatment Foster Home
☐Relative Placement ☐ Juvenile Detention Center/ RTC

REFERRAL SOURCE INFORMATION
Referring Therapist or Psychiatrist's Name, Credentials, Address, and Contact number:

____

Referring Therapist/Psychiatrist's Agency's Name, If Applicable: __________
Are you the current therapist or psychiatrist: Yes___ No ___
If you are not the Current Therapist/Psychiatrist, Please note his/her/their names and contact information: ____

Diagnosis: please use DSM V and ICD-10 code. Severity must be noted for those diagnoses that are subdivided

Primary Behavioral Diagnoses:

Primary Medical Diagnoses:

Social Elements Impacting Diagnoses:

Current Medications (include dosage and frequency):
____

Therapy modalities and frequency of sessions: Individual ____ Family with client ____
Family without client _______; Med. Management:____

Please circle/highlight the following problematic behaviors (if they are occurring):

Suicidal Behavior/Attempts Physical Aggression/Self Injury Verbal Aggression/Oppositional Behaviors

Elopement Animal Cruelty School Refusal/Problems Occurring in School

Sexual Behaviors Substance Use/Experimentation Fire-Setting

Does the client have an IEP/504 plan in school that includes behavior modification. Yes__ No __

If no, is there an upcoming IEP/504 plan meeting scheduled? Yes__ No __

Requested Hours of Service ________________

Placement/Inpatient/ Services History	Location/Provider	Start Date-End Date
# of hospitalizations and what lead to most recent incident		
Out of Home Placement History		
History of services and providers (include outpatient, PRP, TBS, Respite, Day hospital, IEP)		

********Please attach a typed brief, but descriptive, narrative to support referring this client to TBS at THIS time. What are the specific behaviors? Please highlight any progression in the symptoms/behaviors from client's baseline level of functioning; add the frequency of occurrence and the parent's/guardian's responses to the symptoms/behaviors that have led to the request for an in-home behavioral aide. ********

I certify that I am requesting TBS services for the above client and have completed this request for TBS Services (Must hold one of the following MD, PhD, LCPC, LCSW-C,CRNP,APRN)

____

Signature of referring clinician/license Date

____

Supervisor Approval (only for LGPC, LGSW) Date

FAX OR EMAIL TO:

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