

INITIAL THERAPEUTIC BEHAVIORAL SERVICES (TBS) REFERRAL FORM

Butte County Department of Behavioral Health's TBS Office: Phone (530) 879-2456 Fax (530) 879-3932

Client Name: _____ DOB: _____ Today's Date: _____

Current Address: _____

Parent/Caregiver: _____ Phone: _____

Referring Party: _____ Agency: _____

Phone: _____ Fax: _____

Agencies Involved: *(check if applicable)* AB26.5 CSD Probation Other: _____

Case Manager(s): Name: _____ Phone: _____

I. Child/youth is full scope Medi-cal beneficiary under 21? YES NO MediCal # _____

II. Child/youth is receiving Mental Health Services from BCDBH or their Contract Agencies? YES NO

Current Therapist: Name: _____ Organization: _____

Phone: _____ Fax: _____ Email: _____

Therapist/Case Manager contact regarding TBS? YES NO Axis I Dx Code: _____

III. Which of the following conditions have been met by child/youth?

Is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option or has had at least one emergency psychiatric hospitalization within the past 24 months.

Is being considered for placement in a level 12 or above group home as one possible treatment option, though not necessarily the only treatment option or is currently placed in a level 12 or above group home for mental health needs.

and meets the following eligibility criteria? (Check which apply)

Child/youth may need out of home placement, a higher level of residential care or acute care.

Child/youth is transitioning to a lower level of care and needs TBS to support the transition.

Child/youth has previously received TBS services.

IV. Which specific problem behaviors are jeopardizing the current living situation?

Behavior 1:

Behavior 2:

V. Are there any specific needs with regard to the TBS coach's language, culture or gender?

ATTACHED SIGNED RELEASE OF INFORMATION REQUIRED.

Fax referral packet to: BCDBH-TBS at: (530) 879-3932 Or mail to: 500 Cohasset Suite #25 Chico, CA 95926

For Butte County Contract office use only

MCA & Clinical Documentation requested from Therapist for TBS authorization to proceed. YES NO

Disposition: _____

BCDBH TBS Coordinator Signature: _____ **Date:** _____