# 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

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***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:**_____