KINGS COUNTY MENTAL HEALTH PLAN

(TBS) Therapeutic Behavioral Services REFERRAL Form

Fax referral packet to KCBH: 559-589-6928 or Email to: kingsMHPcsoc@co.kings.ca.us

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

***Please complete all items and include latest complete assessment, Plan of Care, Three Most Recent Progress Notes, A signed Release of Information and Court Order and Diagnosis Form.**

Child's Name: ______________________ SSN: ______________

Date of Birth: ______________ Age______ Gender: ______________

Primary Caregiver: ______________________ Phone: ______________

Relationship: ☐ Bio ☐ Foster ☐ Step ☐ Adoptive ☐ Other ______________

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 Anasazi #: ______________ ______________

2. Is child currently receiving EPSDT services (**E**arly **P**eriodic **S**creening, **D**iagnosis & **T**reatment services)? ☐ Yes ☐ No

☐ Therapy ☐ Medication ☐ Other: ______________ Axis I 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 a Level 12-14 Group Home? Level: ☐ 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, and may not successfully transition to a lower level of care? ☐ Yes ☐ No

8. Has the child previously received TBS? ☐ Yes ☐ No

CURRENT PROBLEM BEHAVIORS that are jeopardizing placement or transition

☐ 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:

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

☐ **Expedite Referral**	**Rational:**