THERAPEUTIC BEHAVIORAL SERVICES
REFERRAL

Client Name _____Medi-Cal No._____ Date_____
Client Date of Birth__/__/___ Gender ☐ Male ☐ Female
Child's Current Placement (or Family) Address_____
Parent/Caretaker Name_____ Parent/Caretaker Phone_____
☐ **Family Home** ☐ **Residential Placement (RCL Level ___)** ☐ **Juvenile Hall** ☐ **Other (Specify_____)**
Referring Party_____ Title_____ Phone_____

Is child/youth a full scope Medi-Cal beneficiary under age 21? Yes No
Please list client's current Axis I diagnosis: _____
☐ Check here if Mental Health Assessment was completed in past year (Please attach or indicate any recent data; it is not necessary to repeat information from prior assessment)

Which of the following conditions have been met? (*Must check at least one.*)
☐ At least one emergency psychiatric hospitalization related to current presenting disability within the past 24 months
☐ At risk of psychiatric hospitalization due to presenting disability
☐ Currently placed in a level 12 or above group home for mental health needs
☐ Being considered for placement in a level 12 or above group home through San Bernardino County
☐ Previously received Therapeutic Behavioral Services (TBS) through San Bernardino County

Which is highly likely to occur without additional support? (*Must check at least one.*)
☐ Child/youth may need higher level of residential care or acute care
☐ Child/youth may not successfully transition to a lower level of care

What mental health services is the client currently receiving? ☐ None

List other involved agencies.

Agency	Contact Person	Phone Number

What are the specific problem behaviors jeopardizing current living situation?

Describe alternative approaches that have been tried:

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

*****SIGNED CONSENTS MUST ACCOMPANY REFERRAL.**

FAX REFERRAL PACKET TO DBH/CCICMS TBS-TRAC UNIT at 909-387-7611

(For Departmental Use Only)
☐Eligible ☐ Ineligible (Comments_____)
Signature_____ Name Printed_____ Date_____

Therapeutic Behavioral Services
Referral Form
SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W&I Code 5328

NAME:

CHART NO.:

DOB:

PROGRAM:

8-2011/TBS/CCICMS/dt White