Shasta County Mental Health Services

Therapeutic Behavioral Services (TBS) Referral Form

Referral MUST include current comprehensive assessment

Date: ____________

Utilization Review Fax #: (530) 225-5950 ● Utilization Review email: mceur@co.shasta.ca.us

Referring Party: ____________ Referring Phone No.: ____________

Referring Party's Supervisor: ____________ Supervisor's Phone No.: ____________

Client's Name: ____________ Case No.: ____________ Medi-Cal No.: ____________

Address: ____________ City: ____________ State: ____ Zip: ____

DOB: ____________ Gender: ____________ Ethnicity: ____________

Primary Caregiver: ____________ Caregiver's Phone: ____________

Bio	Adoptive	Step	Resource Family	ITFC	Kin-gap	Dependent of the Court
☐	☐	☐	☐	☐	☐	☐

☐ CFS: Social Worker Name: ____________ Phone: ____________ Fax: ____________

SCHOOL: ____________ Grade: ____ ☐ IEP ☐ Enrolled ☐ Suspended/Expelled

Agencies Involved: (include referring clinician)

Agency	Contact Person	Phone Number	Fax Number

*** Is the client a full scope Medi-Cal beneficiary under age 21?** ◯ Yes ◯ No

*** Is the client receiving Specialty Mental Health Services?** ◯ Yes ◯ No

Current DSM Diagnosis and ICD-10:

*** <u>Which of the following conditions have been met by the client?</u> (check all that apply - must check at minimum of one)**

☐ Is at risk for emergency psychiatric hospitalization or has had at least one emergency psychiatric hospitalization within the last 24 months. DATE: ____________ DATE: ____________ DATE: ____________

☐ Currently placed in a level 12 or above group home

☐ Being considered for placement in a level 12 or above group home and has been reviewed and certified by a Placement Prevention and resource Team (PPRT) or Youth Clinical Care Committee (YCC)

DATE: ____________ ☐ Attached documentation

☐ The client has previously received TBS as a certified member of the class.

*** <u>Does the youth meet with one of the following eligibility criteria?</u>**

☐ The client may need out of home placement, a higher level of residential or acute care

Within the past 6 months the client has received the following Specialty Mental Health Services:

☐ Case Management ☐ Individual Therapy ☐ Group Therapy ☐ Collateral ☐ Rehab ☐ ITFC

<u>What specific behaviors are jeopardizing the client's current living placement?</u>

Fax completed referral form and current comprehensive assessment to Utilization Review Fax # (530) 225-5950

Once the referral has been faxed, please send an email to Utilization Review to inform them that a TBS referral has been sent, at mceur@co.shasta.ca.us