FRED FINCH YOUTH CENTER

Bridges *of* San Mateo

San Mateo County BHRS

Therapeutic Behavioral Services (TBS)

REFERRAL FORM

☐ Spanish Speaking

Date: _____ Social Security # _____

Client Name: _____ Client ID# _____

Date of Birth: _____ Client's Phone# _____

Referred By: (*name & title*) _____ Phone# _____

Agency/Dept: _____ Pager# _____

Parent/Guardian: (Include name, address and phone numbers) _____

_____

_____

☐ Full Scope Medi-Cal

☐ Under 21 years old

☐ Is receiving other specialty Mental Health Services. (*Contact person, agency and phone number*)

☐ Is a certified class member. (*If child/youth meets any of the following criteria, put a check mark*)

☐ 1. Child/youth is placed in group home facility of RCL 12 or above and/or a locked treatment facility.

☐ 2. Child/youth is being considered by the county for placement in facility of RCL 12 or above or for placement in a locked treatment facility.

☐ 3. Child/youth has undergone at least one emergency psychiatric hospitalization within the preceding 24 months. Date(s):

☐ 4. Child/youth previously received TBS while a member of the certified class. Date(s):

☐ It is highly likely that without the additional short term support of therapeutic behavioral services:
(*If child/youth meets either one of the criteria, put a check mark*)

☐ 1. The child/youth will need to be placed in a higher level of residential care, including acute care, because of a change in the child/youth's behaviors or symptoms which jeopardize continued placement in the current facility: OR

☐ 2. The child/youth needs this additional support transition to a lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms are needed to stabilize the child in the new environment.

Clinical explanation of eligibility and reasons for TBS. Cite behaviors that put the current placement or transition at risk and include a note in the chart documenting referral.

_____

_____

_____

_____

_____

_____ _____

County Approval **Date**

AREA OF NEED (*Please check all that apply and briefly explain*:)

- ☐ Daily Living (includes school and vocational functioning) _____
- ☐ Living Situation _____
- ☐ Education and Training _____
- ☐ Emotional and Behavioral _____
- ☐ Social Relationships _____
- ☐ Family Relationships _____
- ☐ Independent Living Skills _____

Target Behaviors and Areas of Intervention: _____

_____

_____

_____

Current Treatment: What services and interventions are currently being provided to address the behaviors and with what results? _____

_____

_____

_____

Any other significant players in child's life:

Name	Relationship	Phone Number

DSM IV MULTIAXIAL DIAGNOSIS (please complete all five axes)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

_____

Axis V: Global Assessment of Functioning (GAF) Scale Current _____ Past Year _____

Diagnosis Estab. By _____ Date _____

BRIDGES of San Mateo Tracking Only

Referral Received: _____

Contact With Case Manager: _____

First Meeting with Child/Youth Family: _____

When completed, please fax to Kimberly Kang, LCSW, Program Specialist, TBS Coordinator.
FAX: 650 872-3626 PHONE: 650 583-1260 x226

Revised 09/9/08