Save Form

five acres
promoting safety, well-being and permanency

TBS REFERRAL PACKET

Please attach the following or indicate document is in Welligent.

	Attached	In Well.
Current Full Assessment or Re-Assessment (Signed and Dated)	☐	☐
Assessment Addendum (if applicable)	☐	☐
SB 785 Service Authorization Request (SAR) - Out of County	☐	☐
Copy of Medi-Cal Card	☐	☐
Current PFI	☐	☐
Consent Form (primary program consent)	☐	☐
Court order for Mental Health Services (MHS) from court, **no more than 1 year old.** (Only for Dependents of the Court clients)	☐	☐
Diagnosis Information Form (if current diagnosis is different from Assessment diagnosis)	☐	☐
Current CTP with Signature Page	☐	☐
TBS Referral	☐	☐

Clinicians: Please submit the signed referral and supporting clinical paperwork to your Clinical Supervisor for review and approval.

Supervisors: Please scan and email referral and supporting paperwork to: TBS Admin
or fax to: 626-398-8590

If you have any further questions, please feel free to contact:

Laura Cervantes	(626) 993-3139
TBS Case Manager	Phone

Name: **IBHIS#**

Agency: **Provider #:**

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PRIMARY PROGRAM FUNDING SOURCE

☐ **CGF** ☐ **FCCS** ☐ **ENHANCED** ☐ **PEI** **(not eligible for TBS)**

CLIENT'S INFO

Name: _____ Gender: M ☐ F ☐ External Referral: Is client a part of Katie-A subclass? ☐ Yes ☐ No

DOB: _____ Age: _____

Social Security #: _____ Medi-Cal #: _____ Ethnicity: _____

Does Client have Out of County Medical?____ If yes, is SAR completed for TBS?____

MENTAL HEALTH PROVIDER

Clinician Name: _____ Agency: _____ Reporting Unit: _____

Phone/ext: _____ Fax: _____ Email: _____

If Internal Client: Cottage: _____ Program: *DMH* FIVE ACRES PROGRAMS

Transferring To New Clinician: _____ Phone: _____

Agency & Rpt. Unit: _____ Email: _____

REFERRING PARTY (if different from above)

Name: _____ Phone: _____ Fax: _____

Relationship to Client: _____ Email: _____ Refer Date: _____

NEED FOR TBS (check one)

☐ To prevent higher level of placement ☐ To ensure transition to lower level of care

CLIENT MEETS CERTIFIED CLASS BY (check one most applicable)

☐ Psychiatric hospitalization in the past 24 months related to current presenting disability.
most recent from _____to _____ Location: _____

☐ In danger of being removed to RCL 12 or above. ☐ Previously received TBS.

☐ Currently placed in a rate classification level (RCL) home 12 or above/and or locked treatment facility for the treatment of mental health needs.

☐ Is at risk of Psychiatric Hospitalization

CURRENT RESIDENCE

☐ Bio home ☐ Foster home ☐ Group home/RCL: _____

☐ Residential/RCL: _____ ☐ Relative's home: _____

☐ Psych. Hospital ☐ Juvenile Hall ☐ Transitional Living ☐ Other: _____

CURRENT CAREGIVER'S INFO

Caregiver: _____ Relationship: _____

Caregiver: _____ Relationship: _____

Address: _____

Phone #: _____ Alt. Phone #: _____ Language: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	**Name:** **IBHIS#** **Agency:** **Provider #:**

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TRANSITIONAL CAREGIVER'S INFO

If transitioning to a lower level of care or other caregiver, indicate transitional caregiver's info below.

☐ Bio home ☐ Foster home ☐ Group home/RCL: _____

☐ Residential/RCL: _____ ☐ Relative's home: _____

☐ Psych. Hospital ☐ Juvenile Hall ☐ Transitional Living ☐ Other: _____

Caregiver: _____ Relationship: _____

Caregiver: _____ Relationship: _____

Address: _____

Phone #: _____ Alt. Phone #: _____ Language: _____

SCHOOL INFO

School Name: _____ Phone: _____ Status: _____

Address: _____ District: _____ Grade: _____

Teacher: _____ Principal: _____

OTHER CONTACTS

CSW: _____ Phone/ext: _____ Fax: _____

Address: _____

Attorney: _____ Phone/ext: _____ Fax: _____

Address: _____

Probation Officer: _____ Phone/ext: _____ Fax: _____

Address: _____

Other: _____

CURRENT DIAGNOSIS – check one Primary and one Secondary

◯ Primary ◯ Sec Code Nomenclature _____

◯ Primary ◯ Sec Code Nomenclature _____

◯ Primary ◯ Sec Code Nomenclature _____

◯ Primary ◯ Sec Code Nomenclature _____

◯ Primary ◯ Sec Code Nomenclature _____

MEDICATIONS

Is the client taking medications? ☐ Yes ☐ No

The appointment is pending for this date: _____ with Psychiatrist: _____

Is the client compliant with medications? ☐ Yes ☐ No

List all current medications and dosages:

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CLINICAL INFORMATION - Special Risks and Concerns (check all that apply)

Asthma: ☐ No ☐ Yes ☐ Unknown Uses/carries an inhaler? ☐ No ☐ Yes
Type: _____

Seizures: ☐ No ☐ Yes ☐ Unknown Takes medication? ☐ No ☐ Yes
Type: _____

Allergies: ☐ No ☐ Yes ☐ Unknown Takes medication? ☐ No ☐ Yes
Type: _____

Other Medical Problems: _____

Physical disabilities? _____

Developmentally Disabled: ☐ No ☐ Yes ☐ Unknown Regional Center Involvement: ☐ No ☐ Yes ☐ Unknown

Substance Abuse: ☐ No ☐ Yes ☐ Unknown Type & Last Used: _____

Gang Involvement: ☐ No ☐ Yes ☐ Unknown ☐ Current ☐ Past In which gang? _____

TARGETED BEHAVIOR

Identify **two (2)** specific behaviors that jeopardize continuation of the current placement or that interfere with the child or youth's transition to lower level of care. **Examples include: Physical Aggression, Verbal Aggression, Oppositional Behavior, Impulsive Behaviors, Disruptive Behaviors, Angry Outbursts, Tantrums.**

Behavior: _____ Frequency: _____ x/ _____ Level: ☐ Mild ☐ Moderate ☐ Severe

If other, describe: _____

Duration: ☐ 10-15 min ☐ 15-30 min ☐ 30 min+ Occur: ☐ Home ☐ School ☐ Community

Describe **specific behavior:** _____

Behavior: _____ Frequency: _____ x/ _____ Level: ☐ Mild ☐ Moderate ☐ Severe

If other, describe: _____

Duration: ☐ 10-15 min ☐ 15-30 min ☐ 30 min+ Occur: ☐ Home ☐ School ☐ Community

Describe **specific behavior:** _____

What other mental health services is the client currently receiving?

Individual: _____ x/ _____ Family: _____ x/ _____ Group: _____ x/ _____

Type: _____

Identify skills and adaptive behaviors that the child or youth is currently using to manage targeted behaviors, any interests, and personal strengths:

Other information/Special needs (ethnic match, language, gender, etc.):

Referring Party/Clinician's Signature: _____ **Date:** _____

(If I am the clinician, I am responsible for notifying the TBS team if for any reason MHS cease as the client must have MHS in order to have TBS in place.)

Clinical Supervisor's Signature: _____ **Date:** _____

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health