COUNTY OF LOS ANGELES
REFERRAL FOR THERAPEUTIC BEHAVIORAL SERVICES (TBS)

1. Date Referred: _____

2. Name of Child: _____ **3. IS #:** _____

4. Birth Date: _____ **5. Age:** _____ **6. Gender:** _____

7. Ethnicity: _____ **8. Medi-Cal #:** _____

9. Social Security #: _____

10. Child's Address:

11. Child's Phone #: _____

12. Parent/Guardian Name: _____

13. Address: _____

14. Phone #: _____

15. Child currently residing with

☐ Parent ☐ Foster Home ☐ Group Home ☐ Other (specify): _____

If Group Home, Name & RCL #: _____

16a. Child's primary language: _____ **16b. Language spoken in home:** _____

17. TBS is needed to: (*check one*)

_____ Prevent placement in a higher level of care

_____ Enable transition to a lower level of care

18. TBS Class Membership (*check all that apply*):

_____ Child in RCL 12 or above, and/or a locked treatment facility for the treatment of mental health needs.

_____ Child is being considered for RCL 12 or above, and/or a locked treatment facility for the treatment of mental health needs.

_____ Child has had one or more psychiatric hospitalization within the past 24 months

If yes, give date(s) _____

_____ Child previously received TBS

If yes, give date(s) _____

19. Describe child's current situation and reason for requesting TBS:

I

_____

_____

_____

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20. Current Diagnosis:

AXIS I _____

_____

AXIS II _____

AXIS III _____ **AXIS IV** _____

AXIS V Current GAF _____

21. Is child prescribed medication? **Yes** _____ **No** _____

Medication & dosage: _____

22. List risk factors, special needs: _____

_____

23. Current mental health service provider:

Name and Title: _____

Agency: _____ Phone: _____

Address: _____

24. DCFS/CSW (if applicable):

Name: _____ Phone: _____

25. Probation Officer (if applicable):

Name: _____ Phone: _____

26. List current behaviors for TBS to address (include frequency of occurrence):

1. _____
2. _____

27. Referring Party:

Name: _____ Phone: _____

Relationship to Client: _____

28. Signature _____ **29. Date:**_____