RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

Jerry A. Wengerd, Director

Riverside County Department of Mental Health
Therapeutic Behavioral Services Referral

INSTRUCTIONS

Please fax TBS referral packet to: TRAC – Fax: (951) 358-6865

DMH Clinic referrals: TBS referral packet includes this referral and the following 5 attachments: 1) Client Care Plan (please include "Refer to TBS" under each goal that is related to the target behaviors); 2) Assessment; 3) Client Registration; 4) Consent for TBS (if minor is a ward or dependent attach minute order to Consent for TBS) and; 5) TBS Eligibility Criteria form.

All other referrals: TBS referral packet includes this referral and the following 3 attachments: 1) Initial Assessment/Client Care: (please include "Refer to TBS" under each goal that is related to the target behaviors); 2) Consent for TBS (if minor is a ward or dependent attach minute order to Consent for TBS); and 3) TBS Eligibility Criteria form.

Client Name: _____ Gender: _____ SS#: _____

Consumer DOB: _____ Age: _____ Client ID #: _____

Full scope Medi-cal: ☐yes ☐no Client MediCal #: _____

Ethnicity: _____ Legal Status: _____

Client's Current Residence: _____

(Street) _____

(City) _____, (State) _____ (Zip)

Phone #: _____

☐Parent Home ☐ Relative Home ☐Foster Home ☐FFA ☐Group Home RCL ____ ☐Other

Name of Group Home (if applicable) _____

Contact Person/Caregiver: _____ Relationship to Child: _____

Contact Person's Phone #: _____ Fax #: _____

DPSS Worker: _____ Phone #: _____ Region: _____

Probation Officer: _____ Phone #: _____ Region: _____

SMH Therapist/CM: _____ Phone #: _____ Clinic: _____

GH Therapist: _____ Phone #: _____ Clinic: _____

Date of last Therapeutic Service: _____ Times per week client receives Therapy: ____

Other services: ☐Group Therapy ☐ Family Therapy ☐ Case Management ☐ Day Treatment

☐ Residential Treatment ☐ Medication Services

Number of Psychiatric Hospitalizations: _____ Date of last hospitalization: _____

TracTeam
Therapeutic Residential Assessment & Consultation Team

Confidential Client Information, See W&I Code 5328

Specific Behaviors to be Targeted:
(Example: Physical Aggression as evidenced by – hitting others, kicking others, pulling hair, etc; and/or Property Damage as evidenced by – hitting holes in walls, throwing objects, etc.)

1. _____
2. _____
3. _____

Targeted Behaviors Frequency and Time of Occurrence:

1. _____
2. _____
3. _____

Antecedents to Target Behaviors:

1. _____
2. _____
3. _____

Successful Interventions:

1. _____
2. _____
3. _____

Client's Strengths and Interests:

Client's and Family's View of Services Needed and Behavior to be Targeted:

Clinicians Recommendations:

Requested Number of TBS Hours Per Week: _____ Estimated Number of Weeks for TBS: _____

Requested days and times of day for TBS:

☐Mon ___Hrs ☐Tues ___Hrs ☐Wed ___Hrs ☐Thurs ___Hrs ☐Fri ___Hrs ☐Sat ___Hrs ☐Sun ___Hrs

TBS Coach - Gender preference: _____ Language preference: _____

Clinician's Signature: _____ **Date:** _____

Clinic/Facility Phone: _____ **Fax:** _____

Signature of Supervisor: _____ **Date:** _____