PerformCARE

Child/Adolescent Services

# Initial Family Based Mental Health Services (FBMHS) Request/Referral Form

Note: All sections of this form must be completed and forwarded to PerformCare when using a prescription letter to recommend FBMH Services.

Date of the request: _____

**Section I: Demographic information**

Member Name: _____ MAID #: _____ Gender: ☐ M ☐ F

DOB:_____ Address: _____

Phone #:_____

County: ☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry

**Section II: Family Composition**

Parent/Legal Guardian/Primary Caretaker

Name: _____Relationship:_____ Marital Status:_____

Please list siblings, adults, and any others residing in the home. If any of the children residing in the home are receiving mental health services list service type and agency name

☐ **Check here if Member only resides with Parent/Legal Guardian/Primary Caretaker noted above**

| First and Last Name | Relationship | Age | Sex | Services | Agency |
|---|---|---|---|---|---|
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If the child's biological mother/father is/are **not** the caretaker(s), please complete the information below:

Biological Mother's Name: _____

Does the child have contact with mother ☐ Yes ☐ No

Biological Father's Name: _____

Does the child have contact with father ☐ Yes ☐ No

Parental History of Mental Health Needs, Incarceration and/or Substance Abuse

**Section III. Additional Child/Family Information**

Child/Family Strengths:

Reason for referral (please provide specific information about behaviors / symptoms including setting(s) frequency, duration, and/or intensity)

Please document any history of violence, harm to self or others, physical/sexual abuse, alcohol or drug use (if over age 10, indicate if substance abuse assessment has been completed), illegal activities or any other dangerous situations in the family.

Please describe why the child is at risk for out of home placement (including hospitalization if applicable) and why other levels of care are not sufficient to address this risk

Date of most recent psychological/psychiatric evaluation: _____ Completed by: _____

Please check if any of the following service systems are involved with the Member

☐ JPO ☐ CYS ☐ Targeted Case Management ☐ ID Support Coordination

Nature of Service System Involvement above:

**Section IV: Current DSM Diagnosis: _____**

**Section V: Medications**

Current Medications / Doses

| Medication type | Dosage | Prescriber |
|---|---|---|
| | | |
| | | |
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Are there any side effects to the current medications ☐ Yes ☐ No

If Yes, what are they?

Is member compliant with medications ☐ Yes ☐ No

Have there been areas of improvement/regression with/without the medications ☐ Yes ☐ No

Comments:

**Section VI: School Information**

School Name: _____ Grade: _____

Classroom Placement:

- ☐ Alternative Ed.
- ☐ Autistic Support
- ☐ Charter School
- ☐ Daycare
- ☐ Emotional Support
- ☐ Head Start
- ☐ Home Bound Instruction
- ☐ Home School
- ☐ Learning Support
- ☐ Life Skills
- ☐ Preschool
- ☐ Private School
- ☐ Regular Education
- ☐ RTF
- ☐ Other: _____

| | | |
|---|---|---|
| Does the Member have an IEP | ☐ Yes | ☐ No |
| Does the Member have an individual educational aid | ☐ Yes | ☐ No |
| Are there other aids in the classroom | ☐ Yes | ☐ No |
| Is there a Behavior Support Plan in the IEP | ☐ Yes | ☐ No |

Does the Member receive any of the following services in the school setting:

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Other: _____

Briefly describe any concerns regarding the member's behavior, social / academic functioning:

**Section VII: Agreement regarding participation in FBMHS**

Was family educated regarding the FBMHS Model and expected intensity of services ☐ Yes ☐ No

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Does one parent/guardian living in the home agree to participate in the FBMHS Program ☐ Yes ☐ No

Who?_____ Relationship: _____

Is the team in agreement to FBMH referral ☐ Yes ☐ No

If no, who is in disagreement and why

| |
|---|
| |

**Person completing this form:**

Name (including credentials): _____Title: _____

Date: _____