Magellan Behavioral Health of Pennsylvania, Inc.
Family-Based Services (FBS) Initial Referral Form

☐ Bedford Co ☐ Bucks Co ☐ Cambria Co ☐ Lehigh Co ☐ Montgomery Co ☐ Northampton Co ☐ Somerset Co

Current evaluation must be attached. Complete all four pages and fax to 866-667-7744.

Date of Referral: _____ Referring Agency Name: _____ Referring Agency MIS #: _____

Referring Agency Staff Name: _____ Referring Agency Staff Email: _____

Referring Agency Phone #: _____ Referring Agency Fax #: _____

Prescribing Doctor's Name: _____

Prescribing Doctor's Email: _____

Prescribing Doctor's Phone #: _____

Member Special Needs/Accommodations: (if Applicable)

Member Name: _____ MA ID # (10 Digits): _____

Preferred Name: _____ Gender/Pronouns: _____

DOB: _____ Age: _____ Race/Ethnicity: _____

School Name: _____ Languages spoken: _____

Grade: _____

Caregiver(s): _____ Relation: _____

Caregiver(s): _____ Relation: _____

Legal Guardian(s): _____ Relation: _____

Home Address: _____

City, State, ZIP: _____

Phone 1: _____ Other contact info:

Phone 2: _____ Other contact info:

Siblings/Others Living within the Home:

Name	Age	Relation

Siblings/Others Living out of the Home:

Name	Age	Relation

Other Agencies Involved (CYS, JPO, MH, PH):

Agency	Contact	Phone #

DSM-5 Diagnosis:

_____

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Member Name: _____ **MA ID # (10 Digits):** _____

Reason for Referral: What is the precipitant? Why now? Please include the severity of symptoms (Frequency, intensity, duration)

Describe Risk for Out-of-Home Placement:

Please describe the family patterns that require treatment via a Family Therapy model:

Member Social Service Agency History, Include all Mental Health Treatment/Placement History: (Include outpatient, inpatient, partial hospital programs, substance use disorders program, JPO placement, CYS placement, case management services, other with dates of treatment.)

Medications:

Name of Medication	Dosage	Prescribing MD	Phone Number

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Member Name: **MA ID # (10 Digits):**

Is Member taking Medications as Prescribed: ☐ Yes ☐ No

Explain: _____

Behavior or Symptom	Factors to Assess Level of Risk for Self-Harm (Check Applicable Items)		
Anxiety	☐ Little or mild	☐ Moderate	☐ High, panic state
Depression	☐ Vague feeling of depression	☐ Withdrawal, some hopelessness	☐ Hopelessness, self-depreciating, very isolated
Behaviors/Conduct	☐ Cooperative, usually gets along	☐ Disagreeable, hostile	☐ Very hostile, impulsive, volatile
Substance Abuse	☐ Occasional	☐ Regularly to excess	☐ Multiple substances, chronic
Suicide Plan	☐ Some thoughts, no plan.	☐ Frequent thoughts, vague plan	☐ Frequent thoughts, solid plan
History of Suicide Behavior	☐ None	☐ Threatens to hurt self	☐ Prior life-threatening behaviors
Communication	☐ Good	☐ Can be engaged	☐ Very closed down
Support System	☐ Good – friends, adults, parents, talkative	☐ Some, but few available will open up	☐ Only one or none
Level of Risk:	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8

Check One	Severity of Psychosocial Stressors Scale: Children and Adolescents (Check Type of Stressor)	
	Acute Events	**Enduring Circumstances**
☐ None	☐ No acute events that may be relevant to the disorder	☐ No enduring circumstances that may be relevant to the disorder
☐ Mild	☐ Broke up with boyfriend/girlfriend	☐ Overcrowded living quarters
	☐ Change in school	☐ Family arguments
☐ Moderate	☐ Expelled from school	☐ Chronic disabling illness in parent
	☐ Birth of sibling	☐ Chronic parental discord
☐ Severe	☐ Divorce of parents	☐ Harsh rejecting parents
	☐ Unwanted pregnancy	☐ Chronic life threatening illness in parent
	☐ Arrest	☐ Multiple foster home placements
☐ Extreme	☐ Sexual or physical abuse	☐ Recurrent sexual or physical abuse
	☐ Death of parent	
☐ Catastrophic	☐ Death of both parents	☐ Chronic life-threatening illness

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Member Name: **MA ID # (10 Digits):**

Check One **Current Out of Home Placement Information (if applicable):**

☐ Currently Placed at: _____

Contact: _____

Contact Phone #: _____

Contact E-mail: _____

Release Date: _____

☐ Family/contact not crisis prone. Placement not likely in foreseeable future.

☐ Some crisis situations. Now manageable. Future placement possible if no changes made.

☐ Crisis generally manageable. Placement probable. History of placement(s).

☐ Frequent crisis situations, few coping mechanisms. Placement may happen at any time.

Referral Completed By: _____ **Title:** _____ **Date Completed:** _____

Is this an Expedited Request? ☐ Yes ☐ No

Expedited requests require an Evaluator's signature, and for the referral to be sent directly to a staffing FBS provider. The FBS provider submits for authorization.

Psychiatrist / Psychologist Name (Print Name Clearly): _____

Psychiatrist / Psychologist Signature: _____

Signature Date: _____

Medical Assistance ID#: _____

National Provider ID#: _____

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