



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

Bucks County Cambria County Delaware County Lehigh County Montgomery County Northampton County

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

Date of Referral: _____ Referring Agency Provider #: _____ Referring Agency Phone: _____

Referring Agency Staff: _____ Referring Agency Staff Email: _____

Referring Agency: _____ Referring Agency Fax #: _____

Recommended FBS Provider: _____

Recommended FBS Provider/Rationale: _____

Member Special Needs: (if Applicable) _____

Need for Team Preference: Male Female No Preference Other: _____

Member Name: _____

MA ID # (10 Digits): _____

DOB: _____ Current Age: _____ Grade: _____

Gender: _____

Race/Ethnicity: _____

Languages spoken in the home: _____

School Name: _____

Home School District: _____

Caregiver(s): _____

Relation: _____

Caregiver(s): _____

Relation: _____

Legal Guardian(s): _____

Relation: _____

Home Address: _____

City, ZIP: _____

Phone 1: _____

Phone 2: _____

Siblings/Others Living within the Home:

Siblings/Others Living out of the Home:

Name	Age	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name	Age	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

DSM-5 Diagnosis:

Agency	Contact	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Check One

Severity of Psychosocial Stressors Scale: Children and Adolescents
(Check Type of Stressor)

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> None | Acute Events | Enduring Circumstances |
| | <input type="checkbox"/> No acute events that may be relevant to the disorder | <input type="checkbox"/> No enduring circumstances that may be relevant to the disorder |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Broke up with boyfriend/girlfriend | <input type="checkbox"/> Overcrowded living quarters |
| | <input type="checkbox"/> Change in school | <input type="checkbox"/> Family arguments |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Expelled from school | <input type="checkbox"/> Chronic disabling illness in parent |
| | <input type="checkbox"/> Birth of sibling | <input type="checkbox"/> Chronic parental discord |
| <input type="checkbox"/> Severe | <input type="checkbox"/> Divorce of parents | <input type="checkbox"/> Harsh rejecting parents |
| | <input type="checkbox"/> Unwanted pregnancy | <input type="checkbox"/> Chronic life threatening illness in parent |
| <input type="checkbox"/> Extreme | <input type="checkbox"/> Arrest | <input type="checkbox"/> Multiple foster home placements |
| | <input type="checkbox"/> Sexual or physical abuse | <input type="checkbox"/> Recurrent sexual or physical abuse |
| <input type="checkbox"/> Catastrophic | <input type="checkbox"/> Death of parent | |
| | <input type="checkbox"/> Death of both parents | <input type="checkbox"/> Chronic life-threatening illness |

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: _____

Psychiatrist (Print Name Clearly)

Psychiatrist (Signature)

Medical Assistance ID#

National Provider ID#