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 Staff: _____ Referring Agency Phone: _____

Referring Agency: _____ Referring Agency Fax #: _____

Recommended FBS Provider: _____

Rationale, if applicable (clinical reason, family, reference, etc.): _____

Parent/guardian/member over age 14 gave consent for release of information:

Written Consent: ☐ Yes ☐ No Date Received: _____

CONSENT MUST BE GIVEN BEFORE A PROVIDER CAN RECEIVE THE CLINICAL INFORMATION NECESSARY TO BEGIN REVIEWING THE CASE.

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

DOB: _____ Current Age: _____ Gender: ☐ M ☐ F Race: (Optional) _____

School Name: _____ Home School District: _____

Caregiver(s): _____ Relation: _____

Caregiver(s): _____ Relation: _____

Legal Guardian(s): _____ Relation: _____

Home Address: _____

City, ZIP: _____

Phone: _____

Siblings/Others Living within the Home:

Name	Age	Relation

Siblings/Others Living out of the Home:

Name	Age	Relation

Other Agencies Involved:

Agency	Contact	Phone #

DSM-5 Diagnosis:

_____

_____

_____

_____

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

Member Special Needs: (If Applicable) _____

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

Release of Information Obtained:

Primary Care Physician: Name: _____ Obtained: ☐ Yes ☐ No

School District: Contact Name: _____ Obtained: ☐ Yes ☐ No

Reason for Referral: (What is the precipitant to this referral? Why now?)

Please Discuss Family Dynamics: (Describe caretaker(s) and identified child/adolescent feelings and motivation about keeping the family together and familial relationships.)

Member Social Service Agency History, Include all Mental Health Treatment/Placement History: (Include outpatient, inpatient, partial hospital programs, substance abuse program with ASAM/PCPC attached, JPO placement, CYS placement, case management services, ICM/RC, with dates of treatment.)

Medications:

Name of Medication	Dosage	Prescribing MD	Phone Number

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

Is Member Compliant with Medications: ☐ 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

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

Discuss Risk for Out-of-Home Placement: _____

_____

_____

Check One **Current/Potential Placement Situation**

☐ Currently Placed at: _____
Contact: _____
Contact Phone #: _____
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#**