SERVICE REFERRAL FORM
w/Clinical Update

Client Name:	Medicaid ID#:
Date of Birth:	Parent/Guardian Name(s):
Address:	Contact Phone #: Contact Email Address:
Today's Date:	☐ Initial (New–Attach Assessment & Tx Plan) ☐ Continue (Reauthorization–Attach Updated Tx Plan) If you don't have one of these forms, Please fill out second page of this form
Referral to: ☐ BHIS ☐ IHP ☐ SOC ☐ BOTH IHP & BHIS	DSM V-ICD 10 Diagnosis:

Problem Areas/Functional Impairments/Target Symptoms:

☐ Cognitive Flexibility Skills
☐ Conflict Resolution Skills
☐ Executive Skills
☐ Problem Solving Skills
☐ Communication Skills
☐ Emotional Regulation Skills
☐ Interpersonal Relationship Skills
☐ Social Skills

(Reason for Referral): Describe Target Symptoms/Functional Impairments/Presenting Problems/Behaviors/Risks

Suggested Goals/Objectives for BHIS **(FOR BHIS REFERRALS ONLY):**

Clinical Update – Include all of the following: Course & Response to Treatment, Medication Changes, Service/Support Changes, Current Mental Status, & Risk/Safety Concerns:

Have you completed a safety plan with the client? ☐ Y ☐ N *If yes, can you please send a copy of the plan with this referral*

BHIS Units Requested:

Service	Units
H2019 Skills Training-Age 20 or less (15 min) Individual	
H2019 Skills Training-Age 20 or less (15 min) Family	

If a BHIS Group is available would you recommend client to attend? ☐ Y ☐ N

(FOR BHIS REFERRALS ONLY)
Length of Time Requested: ☐ 6 Months ☐ 3 Months ☐ Other: _____

Clinician name and credentials:

Clinician signature: Date:

REV 01/23

Assessment and/or Treatment Plan	
Client Name:	Medicaid ID#:
Date of Birth:	Today's Date:
DSM V-ICD 10 Diagnosis:	

Social/Medical/Psychiatric History (include mental status and co-occurring physical illness):

Current & Previous Treatment History (outpatient, inpatient, community based, etc):
Is the family in the process of pursuing and/or seriously considering placement in residential programming? ☐ Y ☐ N
Has this client ever been hospitalized (overnight) for any physical health concern? ☐ Y ☐ N
Has this client ever been hospitalized (overnight) for any mental health condition? ☐ Y ☐ N
Does this client have any nutrition needs and/or concerns that may be indicators of an eating disorder? ☐ Y ☐ N
Comments on treatment history: *(If yes to any of these questions above please explain more)*

Risk Factors:
How would you rate the client's overall level of risk of suicide? ☐ Low ☐ Medium ☐ High
Suicide ☐ None ☐ Intent Without Means ☐ Intent with Means ☐ Contracted not to harm self
Homicide ☐ None ☐ Ideation ☐ Intent Without Means ☐ Intent with Means ☐ Contracted no to harm others
Physical or sexual abuse or child/elder neglect ☐
If 'Yes' patient is ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in family

Therapeutic Treatment Plan Goals, Objectives, Interventions (include BHIS): **(FOR BHIS REFERRALS ONLY)**

Goals:

Objectives:

Interventions:

Clinician name and credentials:

Clinician signature: Date: