CHILDREN'S COMMUNITY-BASED SERVICES REFERRAL FORM

*A psychiatric or comprehensive bio-psychosocial evaluation justifying the medical necessity for and recommending FBS must be completed and submitted with this referral form. Please submit all requests through the provider portal or deliver directly to CBH (you will receive a receipt for tracking purposes). If agency **does not** have access to the provider portal, e-fax referral form to 215-413-8591, submit via secured email to CBH.ClinicalRequests@phila.gov.*

Please indicate the type of FBS team being recommended

☐ General ☐ ASD ☐ ID/DD ☐ Medically Complex ☐ Spanish Language

☐ Spanish Language w/Trauma Informed Focus ☐ Trauma Informed ☐ TF-CBT Specific ☐ Youth Empowerment

Please identify any other FBS specialty needs (i.e. Language Access and Interpretation Services):

Child Information

Last Name: First Name: Preferred Name:

MA#: SSN#: Age: DOB:

Gender Identity

☐ Girl/Female ☐ Boy/Male ☐ Transgender Female ☐ Transgender Male ☐ Gender Queer

☐ Other: Gender Pronouns:

Race/Ethnicity

☐ African American/Black ☐ Asian/Pacific Islander ☐ Caucasian/White ☐ Latina/Latino/Spanish ☐ Multiracial

☐ Other:

Address and Household Information

Address: City: State: ZIP:

Parent/Caregiver Name: Relationship to Child:

Home #: Work Phone #: Cell #:

Emergency Contact: Phone #: Relationship to Child:

Please provide information regarding the family and other household members

Last Name, First Name	Relationship to Child	Age	Current Services

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Relevant Referral Information

Child's Current Services: ☐ AIP ☐ CSU ☐ APHP ☐ CMIS ☐ RTF ☐ BHRS ☐ IBHS ☐ ABA

☐ CTSS ☐ CIRT ☐ ECM ☐ Outpatient ☐ Other:

Referral Source Name: Agency:

Referral Source Phone #: Referral Source Email Address:

Presenting Concerns:

Diagnosis:

Conditions requiring special consideration (medical/physical):

Medications:

School: Grade: Special Edu.: ☐ Yes ☐ No

Primary School Contact: Position: Phone #:

Other Systems Information

Current DHS/CUA Involvement: ☐ Yes ☐ No DHS/CUA Worker Name:

Phone #: Cell Phone #: Email Address:

Current Probation Involvement: ☐ Yes ☐ No Probation Officer Name:

Phone #: Cell Phone #: Email Address:

Agreement to Treatment

I, _____, consent to contact between the current and referring provider and the assigned FBS provider to support the intake and treatment process. I agree to regularly attend and engage in in-home family services, which include therapy sessions, and to work cooperatively and collaboratively with members of my family and the assigned team to achieve treatment goals.

Signature of Caregiver Date

Signature of Youth Date