HSCSN BEHAVIORAL HEALTH HOME SERVICES REFERRAL FORM

☐ **Initial Request** ☐ **Change in Request**

I. PATIENT INFORMATION

Member Name:		☐ M ☐ F	Date of Referral:
Member ID:	Date of Birth:	Age:	School/Grade:

Current Behavioral Health Provider____

Contact Information (phone number & email)______________________________________

Provider Type (School-based, Community Based, etc.)________________________________

***NOTE: An in-home assessment will be performed by an independent licensed behavioral health professional, identified by HSCSN, who will determine whether the enrollee meets medical necessity criteria for home-based services. Upon approval, HSCSN will conduct ongoing review of home care services and effectiveness for medical necessity and appropriateness.**

II. REASON FOR REFERRAL/PRESENTING PROBLEM

Indicate the specific concern(s) which may impact enrollee's health and/or recovery.

III. PERTINENT HEALTH HISTORY – To be completed by referring provider (Licensed health professional)

DSM-IV Diagnosis:
AXIS I:
AXIS II: AXIS III:
AXIS IV: AXIS V:

Medications: Therapies:

Hospitalizations: y /n Hospitalization for Suicidal Ideation/Attempts: y / n Residential Treatment: y / n
(where *yes* is indicated, please give details)

Family Functional History:

History of Substance Abuse:

Lives with: ☐ Parent ☐ Relative ☐ Foster Parent ☐ Group ☐ Lives Alone ☐ Other (please specify)________________

Legal Status: ☐ Probation ☐ Juvenile Justice ☐ Foster Care ☐ Protective Services

History of Abuse: ☐ Verbal ☐ Sexual ☐ Physical ☐ Emotional Abuse

IV. OTHER PERTINENT INFORMATION (Check all that apply)

Behavioral Symptoms	**Non-Compliant Behavior**	**Physical Health Limitations**
☐ Aggression ☐ Emotional Instability ☐ Extreme Impulsivity ☐ Severe Agitation	☐ Medication Compliance ☐ Outpatient Treatment Compliance **Cognitive Limitations** ☐ Mild ☐ Mod ☐ Severe ☐ Intellectual or Dev. Disability	☐ Please specify ________________________________ **Caregiver Limitations** ☐ Cognitive ☐ Social ☐ Physical

Activities of Daily Living (with or without cueing):

Bathing: (Check one)	I ☐	M ☐	D ☐	Social	I ☐	M ☐	D ☐
Grooming: (Check one)	I ☐	M ☐	D ☐	Emotional	I ☐	M ☐	D ☐
Dressing: (Check one)	I ☐	M ☐	D ☐	Attention	I ☐	M ☐	D ☐
Eating: (Check one)	I ☐	M ☐	D ☐	Safety/Judgment	I ☐	M ☐	D ☐
Mobility-Ambulation	I ☐	M ☐	D ☐	Incontinence > 3 yo	Y ☐	N ☐	

I = independent (able to do on their own w/very minimal assistance)

M = moderate dependence (needs minimal to moderate assistance)

D = dependent (cannot perform on their own without maximal assistance)

PROVIDER NAME: Please Print	**Signature/ Date:**
  Phone Number:	