The EDINBURG CENTER

Children's Services (CBHI) Intake (781) 761-5060 Fax: 781-275-7207
205 Burlington Rd • Bedford, MA 01730

Date:

IHBS (In Home Behavioral Service) Referral Form

1: Youth Information:			
Youth Name:			
Address:			
City:	State:	Zip:	
Date of Birth: Age:	Ethnicity:	Gender:	

2: Parent/Guardian & Family Information		
Parent/Guardian Name:		Relationship:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email address:		
Parent/Guardian Name:		Relationship:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email address:		
Foster Family ☐ Yes ☐ No	Adoptive Family ☐ Yes ☐ No	
Primary Language Spoken at Home:	Spoken by youth:	
Safety concerns in-family: ☐ Yes ☐ No neighborhood ☐ Yes ☐ No (describe on separate sheet)		
Siblings names, ages, gender:		
Names of other adults living in the house:	Caregiver?	
_____	☐ Yes ☐ No	
_____	☐ Yes ☐ No	

Family Availability		
Days of the Week:	Start time:	End Time:
Monday		
Tuesday		
Wednesday		

Thursday	
Friday	
Saturday	
Sunday	

3: Insurance Information: (Must be MassHealth Standard or Commonhealth)

Masshealth # (MMIS): MCE # (if applicable):

Masshealth MCE (Behavioral Health) plan (circle one):
MBHP Tufts-Network Neighborhood (NHP) Fallon BMC (Boston Medical)

Commercial Insurance & #:

4: Medical Necessity Criteria:

1. Does the youth display severe, persistent behavior problems? ☐ Yes ☐ No
2. Does the youth have a Behavioral Health diagnosis? ☐ Yes ☐ No
3. Has the youth not been able to benefit from talk therapy? ☐ Yes ☐ No
4. Does youth exhibit atypical or disruptive behavior that significantly interferes with daily functioning and activities or that poses a risk to the member or others related to aggression, self-injury, property destruction etc? ☐ Yes ☐ No
5. Have traditional treatment approaches not been effective for this youth?: ☐ Yes ☐ No

Please attach the required Masshealth documentation:

☐ **Release of Information (if not parent)** Copy attached: ☐ Yes ☐ No

☐ **Treatment Plan <u>with a goal for IHBS</u>** Copy attached: ☐ Yes ☐ No

☐ **CANS** Copy attached: ☐ Yes ☐ No

☐ **Comprehensive Assessment** Copy attached: ☐ Yes ☐ No

☐ **Risk Management/Safety Plan** Copy attached: ☐ Yes ☐ No

Does the youth have an autism diagnosis? ☐ Yes ☐ No

Does the youth have other developmental delays? ☐ Yes ☐ No

5: Medical Information:

Diagnoses (DSM 5 diagnosis & ICD 10 codes):

Who made the diagnosis (name/title)

Practice/Agency:

Address: Phone:

Primary Physician: Phone:

Practice Name:

Address:

City:	State:	Zip:
Please attach latest physical and immunization record	Copy attached: ☐ Yes ☐ No	
Name &describe any youth medical concerns:		
Does youth have allergies (list type):		
Does youth have history of seizures:		
Describe any youth physical or other intellectual disabilities:		
Does youth take medication (list name, dosage and times):		

6: Others involved with youth:	
Intensive Care Coordinator (ICC): Family Partner: Agency:	Phone: Phone: Phone:
Prescriber: Practice:	Phone: Phone:
In Home Therapist (IHT): TT&S: Agency:	Phone: Phone: Phone:
Outpatient Therapist: Agency:	Phone: Phone:
Therapeutic Mentor: Agency:	Phone: Phone:
State Agency (DDS, DCF, DYS): Worker:	Phone: Phone:
Natural Support:	Phone:
Other:	Phone

7: School Information:		
School/Daycare/ EI name:		Grade:
Address:		
City:	State:	Zip:
School contact name:	Phone:	
Type of classroom (circle one): Reg Ed self-contained Inclusion Home based		
Date of last IEP:	Copy attached: ☐ Yes ☐ No	
School Behavior Support Plan: ☐ Yes ☐ No	Copy attached: ☐ Yes ☐ No	

8: Behavioral History
Does the youth display any of the following behaviors (circle)

Verbal aggression Physical aggression Self-injury Non-compliance Destruction of Property

Inflexible routines or rituals Stereotypy (self-stimulating behaviors) Eating/mealtime behaviors

Sleeping/bedtime issues Tantrumming Bolting Other _____

Please describe what the target behaviors look like:

How often does the behaviors occur? (specify frequency per day/week, length and level of intensity)

Describe how the behaviors are currently handled:

How effective are the procedures in a) stopping behavior b) decreasing/increasing the frequency or intensity of the behaviors

Do any behaviors occur at school? If so, which ones:

Has the youth been hospitalized, CBAT, placed residentially or used emergency respite in the last two years? Briefly explain:

Is the youth toilet-trained? ☐ Yes ☐ No

9: Referral source (if other than parent/guardian)

Referral Name:		Relationship:
Agency/Practice/Facility:		
Address:		
City:	State:	Zip:
Work Phone:	Cell Phone:	
Email address:		