Building Communities Today for Tomorrow, Inc.
"Real Issues Deserve Real Work"

TBS Referral Form

Consumer Information	
Name:	DOB:
MA or VO#:	SS#:
Diagnosis (Included IDC-9 code and description)	
Axis I:	Description:
Axis II:	Description:
Axis III:	Description:
Axis IV:	Description:
GAF (Current):	
Highest Past Level:	
Referring Agency:	
Referring Provider:	Phone:
❑ TBS Provider Requested: ❑ Need to find a Provider	
Detail increased behaviors or issues that are occurring in the home, indicating precipitating factors:	
Brief History of consumer' behavioral history (include placement history/hospitalizations, previous services):	
Indicate goals of service and how TBS will be rehabilitative for the consumer:	
Indicate Parent/Guardian working with the aide in the home:	
Name:	Relationship:

*** PLEASE ATTACH THE CURRENT PSYCHOSOCIAL ASSESSMENT***

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Address:	Phone:
Legal Guardian? Check one: Yes ❑ No ❑	
Name of legal guardian in not person above:	
Address of legal guardian:	
Phone:	
Identify Treatment Foster Care, Therapeutic Group Home, or facility if applicable:	
Name of Facility:	Phone:
Address:	
List interventions or programs already in place for the consumer:	
Consumer's current therapist:	Phone:
I certify that I am requesting TBS services for the above client and have completed this letter of request for TBS services: *[Must be an independtly licensed clinician (MD, PhD, LCPC, LCSW-C, CRNP, APRN]* Signature of referring clinician/license: Date: / / Co-signer/license: (required for clinicians without independent license, i.e. LGPC, LGSW) Date: / /	
Please either submit this form along with the current psychosocial via Provider Connect OR fax to: 2901 Druid Park Dr. Suite A-207 Baltimore, MD 21215 Office: 410-467-6600 Fax: 410-225-9110	

*** PLEASE ATTACH THE CURRENT PSYCHOSOCIAL ASSESSMENT***