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Referral Form for Behavior Consultation

Instructions: This form is to be completed by the case manager, support coordinator, or agency administrative representative through which the individual receives residential or other treatment services. Once this referral form has been submitted, it will be evaluated by a representative of Pledger Behavior Consulting (PBC), and if approved, a prospective calendar and a cost plan for services will be generated. Please include all information below as it applies to the individual being referred.

1. Individual Information:

a. Name:

b. Phone number of primary contact:

c. Address:

d. DOB: **Current Age:**

e. Medicaid #:

2. Family Information

a. Name of (circle one) Guardian/Conservator/1st Representative:

b. Relationship to Individual:

c. Home phone number: **d. Cell phone number:**

e. Best time to call: **f. Best time to call:**

3. Referring Agency Name:

a. Case Manager/Support Coordinator Name and Contact Information:

b. Name of Day Program (if applicable):

4. Date of Referral:

5. Has the individual's circle of support (COS)/treatment team requested services?

6. When would you like to request that services begin?

7. Reason for referral (please be as specific as possible, giving examples and perceived frequency of the behavior(s)). Attach more pages if necessary:

8. Services requested:

- **a. Behavior Assessment (required for BSP)**
- **b. Behavior Support Plan (required for behavior services)**
- **c. Behavior Services**
- **d. All of the above**

9. Please include the current ISP, Risk Assessment (if there be one), the names and contact numbers for all of the people on the COS/treatment team.
(Use this page as needed for including any other information you may deem pertinent.)

Signature of person completing this form **Date**