Date: _____

BBCBC Assessment and Service Referral Form

Child Name: _____ DOB: _____ Medicaid #: _____ Insurance: _____

Case Manager: _____ Phone#: _____ Supervisor: _____ Phone#: _____

Caretaker: _____ Address: _____ Phone#: _____ Relationship: _____

Guardian: _____ Address: _____ Phone#: _____ Relationship: _____

Services Requested

Provider Name: _____ Phone#: _____ Email: _____

Assessment		Treatment
☐ Biopsychosocial Eval	☐ Substance Abuse Eval	☐ Individual Therapy - Office
☐ Psychological Eval	☐ Psychiatric Eval	☐ Individual Therapy - On Site (TBOS)
☐ Bonding Assessment	☐ Medication Eval	☐ Family Therapy
☐ Parenting Assessment	☐ Forensic Case Review	☐ Grief/Loss Therapy
☐ Psychosexual Assessment	☐ Forensic Case Review with Psychological Eval	☐ Sexual Abuse Treatment
☐ Full Psychosexual Eval		☐ Anger Management Counseling
☐ Batterer's Intervention Eval	☐ Long Term Parenting/Bonding Eval (requires Court Order)	☐ Substance Abuse Treatment
Other _____		☐ Domestic Violence Counseling Other _____

Factors in Request		
	Case Plan Requirement? ☐ Yes ☐ No	Court Ordered? ☐ Yes ☐ No
	Is there a deadline for completion? ☐ Yes ☐ No	If so, date: _____

Referral questions or need for service

_____

If you are requesting an evaluation, please be specific about what you hope to learn. If you are requesting a service, please list what issue you would like addressed or goals you wish to see accomplished.

Other relevant information

_____

Referral Documentation:

☐ CBHA ☐ Counseling Records ☐ Case Plan ☐ Criminal History ☐ Previous Evals ☐ Shelter Order ☐ Judicial Review

☐ Correspondence ☐ Education Records ☐ PDR/PDS ☐ Prior Abuse Records

Other _____

Relevant Collateral Contacts	Name		Phone		Relationship	
	Name		Phone		Relationship	