



PHYSICIAN/PSYCHOLOGIST RECOMMENDATION FOR FBMHS

Children and adolescents and members of their families are eligible to receive Family Based Mental Health Services if:

1. A child or adolescent has a mental illness or emotional disturbance and is determined to be at risk for out-of-home placement, such as inpatient psychiatric care, residential care, foster care, etc.
2. At least one adult member of the family agrees to participate in the service.

I am recommending that _____
(Name)

be considered for Family Based Mental Health Services because: _____

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

(Physician's signature)

(Date)

(Name)

(Address)

(Phone #)