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: _____

_____

_____

DSM diagnosis:
Behavioral Diagnosis_____

Medical Diagnosis _____

Social Elements Impacting Diagnosis:_____

(Optional) Functional Assessment:
Assessment:_____Score:_____

_____
(Physician's signature) (Date)

_____
(Name)

_____
(Address)

_____
(Phone #)