

**THERAPEUTIC BEHAVIORAL ON-SITE SERVICES
INITIAL REVIEW**

Client Demographic Information:

Enrollee Name: _____
Enrollee Medicaid #: _____
Date of Birth: _____
Current Provider and
Level of Care: _____
Address/Phone #: _____

1. Call Demographics:

Date called to Magellan: _____
Name of Coordinator: _____
Response/review appt
date and time: _____
Follow up issues: _____

2. Requested Level/Service:

Provider Name: _____
Address/Zip: _____
Contact Person: _____
Phone #/Email: _____
Fax #: _____
Requested Begin Date: _____

3. Level of TBOS requested:

Therapy Behavior Management Therapeutic Support

4. Reason for requested service (referral source, why now)?

**THERAPEUTIC BEHAVIORAL ON-SITE SERVICES
INITIAL REVIEW**

5. Clinical Diagnosis (all five axes):

	CODE	DESCRIPTION
I.		
II.		
III.		
IV.	Current Psychosocial Stressor(s):	
V.	GAF (Current):	GAF (Past Year):

6. Risk Assessment (e.g. suicidal, homicidal, plan):

7. Medical/Medications (physical and behavioral): [include dosage & frequency]

8. Psychosocial Summary (abuse/neglect, cultural, legal, substance abuse):

9. School (grade, special ed, absenteeism, suspension/expulsion):

10. Location where problem behaviors occur:

**THERAPEUTIC BEHAVIORAL ON-SITE SERVICES
INITIAL REVIEW**

11. Previous treatment:

Type of Service/Support:	
Dates:	
Outcome:	
Type of Service/Support:	
Dates:	
Outcome:	
Type of Service/Support:	
Dates:	
Outcome:	
Risk for Higher Level Care?	
Why?	
If no prior treatment, what has been considered?	

12. Current providers and supports:

Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	

13. Strengths:

14. Goals (behavior-based):

**THERAPEUTIC BEHAVIORAL ON-SITE SERVICES
INITIAL REVIEW**

15. Barriers:

16. Discharge plan:

17. Anticipated length of treatment:

**THERAPEUTIC BEHAVIORAL ON-SITE SERVICES
CONCURRENT REVIEW**

Client Demographic Information:

Enrollee Name: _____
Enrollee Medicaid #: _____
Date of Birth: _____
Current Provider and
Level of Care: _____
Address/Phone #: _____

1. Call Demographics:

Date called to Magellan: _____
Name of Coordinator: _____
Response/review appt
date and time: _____
Follow up issues: _____

2. Requested Level/Service:

Provider Name: _____
Address/Zip: _____
Contact Person _____
Phone #/Email: _____
Fax #: _____
Requested Begin Date: _____

3. Level of TBOS requested:

Therapy Behavior Management Therapeutic Support

**THERAPEUTIC BEHAVIORAL ON-SITE SERVICES
CONCURRENT REVIEW**

4. Clinical Diagnosis (all five axes):

	CODE	DESCRIPTION
I.		
II.		
III.		
IV.	Current Psychosocial Stressor(s):	
V.	GAF (Current):	GAF (Past Year):

5. Risk Assessment (e.g. suicidal, homicidal, plan):

6. Changes in medical/medications (physical and behavioral): [include dosage & frequency]

7. Changes in psychosocial situation (abuse/neglect, cultural, legal, substance abuse):

8. Changes in school (grade, special ed, absenteeism, suspension/expulsion):

**THERAPEUTIC BEHAVIORAL ON-SITE SERVICES
CONCURRENT REVIEW**

9. Changes in current providers and supports (type of service/support, date began):

10. Strengths:

11. Progress toward goals (behavior-based):

12. Level of participation of child, family, school:

13. Barriers:

14. Discharge plan:

15. Anticipated discharge date:
