BEHAVIORAL SERVICES REFERRAL FORM

**Email referral and supporting documents to** [**cbrooks**](mailto:cbrooks)**@mycri.org**

1. **Identifying Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Individual: |  | Date of Referral: |  |
| DOB: |  | Medicaid #: |  |
| Social Security #: **(Must have to begin services)** |  | Funding Source: |  |
| Home Address/  Residential Provider:  **(Indicate residence by circling)** |  | Home Contact:  Phone #:  Fax #:  Email: |  |
| Day Program/School: |  | Contact: Phone #:  Fax #:  Email: |  |
| PCP Annual Date (Med-Waiver): |  | Referring Contact:  Phone #:  Fax #:  Email: |  |
| Guardian/ AR: |  | Phone #:  Fax #:  Email: |  |
| Reason for Referral: |  | | |

1. **Diagnoses** (Please list all DSM diagnoses and date of last evaluation):

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1. **Medications:** Attach most recent list of medications.

1. **Behaviors of Concern** (please check all that apply and indicate the frequency (how often) and the severity (mild, moderate, or severe):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Behavior** |  | **Topography** | **Frequency**  **(How often does the**  **behavior occur?)** | **Severity** |
| **Please check all that apply** | **What does it look like?** |
| Physical Aggression | Towards Others |  |  |  |
| Towards Property |  |  |  |
| Self-injurious Behavior | Head banging |  |  |  |
| Biting |  |  |  |
| Scratching/Picking |  |  |  |
| Pica |  |  |  |
| Other: |  |  |  |
| Inappropriate  Verbal Behavior  (Please describe) |  |  |  |  |
| Elopement/  Wandering  (Please describe): |  |  |  |  |
| Obsessive  Compulsive  Behavior |  |  |  |  |
| Noncompliance |  |  |  |  |
| Inappropriate or  Unsafe Sexual  Behavior |  |  |  |  |
| Other  (please describe) |  |  |  |  |

1. Has this individual had a behavior plan before? Yes\_\_\_\_\_ No\_\_\_\_\_\_ If yes, please provide a copy.

1. Please describe any other relevant concerns (illnesses, recent changes, etc.) the individual is currently exhibiting.

1. What interventions or techniques have been used in the past? What strategies are currently being used to address the behavior of concern?

1. Is the individual currently receiving behavior services (in-home ABA/another consultant, etc.)?
2. Please include a copy of the most recent Person Centered Plan, SIS, and Psychological Evaluation.

**Contact Information:**

Toi-Kai Williams, MEd, BCBA, LBA

Director of Behavioral Services

**CRi – Choice. Respect. Independence.**

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Chantilly, Virginia 20151

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Email:  [twilliams@MyCRi.org](mailto:twilliams@MyCRi.org) | Website:  [www.MyCRi.org](http://www.mycri.org/)

Med-Waiver Therapeutic Consultation NPI# 139-682-0098

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Referring Person/Relationship to individual Date

Contact Information (phone, email): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MUST HAVE THIS CONSENT TO START ASSESSMENT PROCESS**

Consent for Behavioral Assessment

Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to a behavioral assessment completed by CRi, and to share relevant information necessary for a successful assessment. For further information, contact Toi-Kai Williams, BCBA, LBA at [twilliams@myCRi.org](mailto:twilliams@myCRi.org) or Claudette Brooks at cbrooks@mycri.org.

**Consent is given to complete a behavioral assessment and initiate behavioral services.**

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| Individual and/or Guardian/AR | Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Support Coordinator/Social Worker/Other | Date |