COMMUNITY CARE
Behavioral Health Organization

Family Based Prescription Letter
All Counties

Date:

Please indicate your use of this Family Based Prescription Letter:

◯ Evaluation within the last 6 months ◯ Evaluation within the last 60 days, but did not recommend FB

◯ No recent evaluations; prescription letter to initiate an evaluation to occur in next 30 days

Member Information

Following my recent evaluation of Member Name: (First) _____ (Last) _____

MA ID #: | | | | | | | | | | | DOB: *(mm/dd/yyyy)*

On the following date *(mm/dd/yyyy)* _____ and after considering less restrictive, less intrusive levels of care such as: _____

it is medically necessary that this child/adolescent receives Family Based Mental Health Services.

This level of care is indicated because of (please check all that apply)

☐ Risk of out of home placement ☐ Step-down from Inpatient or RTF ☐ Little or no progress in less restrictive/intrusive services

Specify type: _____

Current behavioral concerns and symptoms (frequency and severity):

Family concerns (please check all that apply and give an explanation):

☐ Needs parenting skills _____

☐ Needs communication skills _____

☐ Additional mental/physical health problems in the home _____

☐ Other _____

Despite the above behaviors, this child can currently be managed at home without a risk to the safety of self or others with the support of Family Based Services.

◯ Yes ◯ No If no, explain _____

The following treatment issues should be addressed by the Family Based provider:

MISA screen completed on: *(mm/dd/yyyy)* _____ Diagnosis: _____ Last Use: _____

What is the plan for treatment?

Evidence of domestic violence in home? ◯Yes ◯No **Domestic Violence** screen completed on: *(mm/dd/yyyyy)*

Current? ◯Yes ◯No By history? ◯Yes ◯No Referral made? ◯Yes ◯No To Whom/Where?

Tobacco screen completed on: *(mm/dd/yyyy)*

Tobacco user? ◯Yes ◯No

Has cessation been discussed? ◯Yes ◯No

Is member interested in a referral for tobacco cessation? ◯Yes ◯No

☐ Referred to Tobacco Cessation Therapist/Program

☐ Referred to Quit Line

Pregnant? ◯Yes ◯No ◯N/A Height: ___ ft ___ in Weight: ___ lb

Past and current mental health treatments/services include (please check all that apply):

Level of Care	Facility	Start Date *(mm/dd/yyyyy)*	End Date *(mm/dd/yyyyy)*
☐ Outpatient MH Counseling			
☐ Medication Management			
☐ SUD Counseling			
☐ IBHS			
☐ Family Based Mental Health Services			
☐ Partial Hospitalization Program			
☐ School-Based Partial Hospitalization			
☐ ICM/RC Services			

Current Diagnoses:

Please include a primary behavioral health diagnosis. Other diagnoses may be included.

Behavioral Health

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Medical Conditions/ Physical Health Issues

Medical Conditions/ Physical Health Issues

Medical Conditions/ Physical Health Issues

Social Stressors

Description of Recent Stressors (Please check all that apply):

- ☐ Problems with primary support group — Specify: _____
- ☐ Problems related to social environment — Specify: _____
- ☐ Educational Problems — Specify: _____
- ☐ Occupational Problems — Specify: _____
- ☐ Housing Problems — Specify: _____
- ☐ Economic Problems — Specify: _____
- ☐ Problems with access to health care services — Specify: _____
- ☐ Problems related to interaction with legal system /crime — Specify: _____
- ☐ Other psychosocial and environmental problems — Specify: _____

Medication	Dose	Frequency

Medications prescribed by: _____

License Number: _____

Prescriber's MA Number: _____

Prescriber's NPI Number: _____

Print Name: _____

Prescriber's Signature: _____