COMMUNITY CARE
Behavioral Health Organization

Family Based Best Practice Prescription Letter
All Counties

Date:

Following my recent evaluation of | Member Name | MA ID # | Date of Birth

On the following date 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
  Specify type:
- ☐ Step-down from Inpatient or RTF
- ☐ Little or no progress in less restrictive/ intrusive services

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: Diagnosis: Last Use:

What is the plan for treatment?

Evidence of domestic violence in home? ◯ Yes ◯ No **Domestic Violence** screen completed on:

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

Does child/adolescent smoke cigarettes? ◯ Yes ◯ No Date assessed: Pregnant? ◯ Yes ◯ No ◯ N/A

Smoking cessation discussed? ◯ Yes ◯ No

Does child/adolescent have an Axis III diagnosis of Obesity? ◯ Yes ◯ No Height: ft in Weight: lb

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

Level of Care	Facility	Start Date	End Date
☐ Outpatient MH Counseling			
☐ Medication Management			
☐ D&A Counseling			
☐ BHRSCA (MT, BSC, TSS)			
☐ Family Based Mental Health Services			
☐ Partial Hospitalization Program			
☐ School-Based Partial Hospitalization			
☐ ICM/RC Services			

Current Diagnoses:

Axis I:

Axis I:

Axis II:

Axis III:

Axis III:

Axis IV 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:

Axis V: Current GAF: Highest GAF in Past Year:

Medications being prescribed for this child by: License Number

Medication	Dose	Frequency

Print Name:

Prescriber's Signature:

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