TRANSITION TO INDEPENDENCE PROCESS (TIP)

REFERRAL FORM

Phone: (610) 209-8590 Fax: (267) 818-2212 Email: tip@centralbh.org

CENTRAL

Central Behavioral Health is providing the TIP Program in Montgomery County. TIP serves Transition Age Youth (TAY) age 16-26 with emotional and/or behavioral struggles, along with a primary psychiatric diagnosis. This referral is to be completed <u>together</u> with the TAY and referral source person.

Name:	**Phone #:**	**Email:**	
Address (If homeless, last known address):	**DOB:**	**Gender:**	**SSN:**
Parent/Guardian:	**Phone#:**	**Email:**	
Emergency Contact:	**Phone#:**	**Email:**	
School Currently Attending and Contact Person:	**Phone#:**	**Email:**	
Referral Source:	**Phone#:**	**Email:**	

Reason(s) for Referral:

- ☐ Educational Opportunities
- ☐ Living Situation
- ☐ Employment and Career
- ☐ Community Life Functioning
- ☐ Personal Effectiveness and Wellbeing

Strengths/Interests (Include Support Network and Community Involvement):

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Services and Supports (C for current service; P for past service; R for referral made to service; or N for needed):

BH/ID						MEDICAL		D&A	
	Partial Hospitalization		BHRS		HI FI WrapAround		Primary Care Physician		AA/NA/Dual Recovery
	Outpatient Therapy		IOP		ACT		Specialists (List):		Rehab
	Family Based Services		RTF/CRR		MST	FORENSIC		OTHER SUPPORSTS	
	Medication Management/Psychiatrist		BCM/RC/D&A ICM		ID Supports Coordinator		Probation/Parole		Children & Youth Involvement
							Behavioral Health Court		

Diagnoses:

Please attach the most recent psychiatric or psychological evaluation

Insurance		Income	
☐ Private Insurance	☐ Pending	☐ Employment	Amount $
☐ Medical Assistance / Magellan	☐ Medicare	☐ SSI/SDI	Amount $
		☐ Other:	Amount $

List Prescribed Medication:

Comments:

TAY Signature: _____ **Date:** _____

Referral Source Signature: _____ **Date:** _____