



Momentum Services, LLC

Helping Today... Building Tomorrow

Family Based Mental Health Services (FBMHS) Referral Form

Name of Child: _____

D.O.B. _____ M/F: _____ SS#: _____

Parent/Guardian: _____ MA#: _____

Address: _____ Phone#: _____

_____ Cell #: _____

Please indicate past & current services or agencies involved with the child/family:

Service	Date / Current	Service	Date / Current
Counseling		MH Case Management	
Med Management		MR Case Management	
Wraparound		Children & Youth	
Drug & Alcohol		Juvenile Probation	
Inpatient Hospitalization		Foster care	
Partial Hospitalization		Residential	
Group Therapy		Juvenile facility	
Crisis Intervention Visit(s)		Other:	

Has the child had a recent MH hospitalization, crisis visit(s) and/or placement?

Yes No Dates: _____

Has there been a recommendation for FBMHS by a licensed physician, psychologist or psychiatrist? Yes No Date of RX: _____

Has there been a recent (within 1 year) psychological/psychiatric evaluation? Yes No Date of eval: _____

Mental Health Diagnosis: _____

Have FBMHS been explained to at least one parent? Yes No

Are they willing to be an active participant in treatment? Yes No

Please circle behaviors of child that place them or others at-risk:

suicidal attempt	suicidal ideation	cutting
promiscuity	running away	staying out all night
illegal acts	drugs &/or alcohol	truancy
cruelty to animals	self-harm	aggression towards others
verbal aggression	property damage	

others: _____

Please describe any other relevant information in regards to the family, parents, siblings, relationships, dynamics, living situation, parenting, etc.

Referred by: _____ Date: _____

Phone #: _____ Ext: _____

Date of Staff Response: _____

Forward Referrals to: Julie E. Pepo, B.S.W. – FBMHS Director
Momentum Services, L.L.C.
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Chambersburg, PA 17201
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717-262-2486 (Fax)
www.mymomentumservices.com

Please include a signed release of information with all referrals!