

**T. B. S. CHECKLIST TO DOCUMENT T.B.S. CATEGORY –  
AT RISK FOR PSYCHIATRIC HOSPITALIZATION**

1. Child's behavior or symptoms places child at risk of potential psychiatric hospitalization.

\_\_\_ yes \_\_\_no

2. Child has a previous history of at least one hospitalization. \_\_\_ yes \_\_\_no

If yes, check one of the following: hospitalized in the last \_\_\_5 years, \_\_\_10 years

3. Child is currently receiving mental health treatment of both psychotherapy (or intensive case management through CCICMS) and psychiatry for medication.

\_\_\_ yes \_\_\_no

4. The psychotherapist, case manager, and/or psychiatrist agree that child is at risk for psychiatric hospitalization.

\_\_\_ yes \_\_\_no

**I certify that this client should qualify for the above TBS category on the basis of the above information.**

Signature of Clinician or SSP \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name/Title/Licensure \_\_\_\_\_ Agency/Clinic: \_\_\_\_\_

Optional Signature of Psychiatrist \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name \_\_\_\_\_ Agency/Clinic: \_\_\_\_\_

**If the above signature is not a licensed clinician, a co-signature by the clinician's supervisor or SSP's supervisor is needed below (not needed if psychiatrist's signature obtained).**

Signature of CS, CTII or SSSP \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name/Title/Licensure \_\_\_\_\_

**Disclaimer: Your signature(s) ensure(s) that there is congruent information in your records which justifies your answers.**

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Therapeutic Behavioral Services  
At Risk for Psychiatric Hospitalization Checklist

Confidential Patient Information  
See W&I Code 5328

NAME:

DOB:

AGENCY:

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*The section below is to be completed to show agreement by the TBS provider:*

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It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of TBS that the child will need to be placed in a higher level of **acute care** because of a change in the child's behaviors/symptoms, or a change in behavior/symptoms is expected and TBS is needed to stabilize the child in the new environment. *Note: The provider must document the basis for the expectation that the behavior or symptoms will change, in their own record (per DMH letter #04-11 dated 10-21-04).*

Signature of TBS Provider \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name/Title/Licensure \_\_\_\_\_

**If the above signature is not a licensed clinician, a co-signature by the licensed supervisor is needed below.**

Licensed Supervisory Signature of TBS Provider \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name/Title/Licensure \_\_\_\_\_

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