

Mid-Ohio Psychological Services, Inc.
Home-Based Therapy Assessment and Referral

Client Name: _____ Client ID: _____ Date: _____

Please indicate identified Home-Based Therapy(HBT) needs for the referred consumer. All identified needs should be incorporated into the existing Individualized Service Plan (ISP) once HBT has been approved.

Who will be involved in the case?

- Transfer to home based therapist
- To remain with primary individual therapist with HBT as an adjunct to services

List the specific issue to be addressed by the HBT program:

Anticipated duration of HBT: _____

What is the purpose of the referral (why HBT as opposed to/in addition to traditional therapy)?

- Client and family have a pattern of an unstable home environment, which impacts client's functioning and progress towards the treatment goals.

Explain: _____

- Client and family are unable to generalize skills into the natural environment, which impacts client's functioning and progress towards the treatment goals.

Explain: _____

- Client's natural environment plays a specific role in client's level of functioning and progress towards the treatment goals.

Explain: _____

- Transfer** of Individual Counseling to HBT due to a large family/foster family with multiple children and multiple service providers.

Explain: _____

- Transfer** of Individual Counseling to HBT due to client having multiple mental health needs along with medical needs, which complicate service delivery in the clinical setting.

Explain: _____

- ❑ **Transfer** of Individual Counseling services to HBT due to history of no shows and/or transportation problems due to mental health condition.

Explain: _____

Names of other family members involved with MOPS:

Other MOPS providers involved in this family system:

Diagnostic Considerations

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Systemic Involvement

Job and Family Services

Child Protective Services

Court/Criminal Justice System

AOD providers

Other mental health providers

Therapist Requesting HBT be added: _____

Supervisor: _____

____ Approved

____ Disapproved: Explain: _____

HBT Clinician assigned to the case: _____

HBT Coordinator Signature: _____ Date: _____