Holdsambeck Behavioral Health

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Tri-Counties Regional Center Referral Form

Service Coordinator: _____Today's Date: _____

Client Name: _____

UCI#: _____ DOB: _____

Guardian Name: _____Guardian Phone: _____

Guardian Email: _____

Dates of Authorized Service: Start _____End _____

Is this client at-risk for, or have, a diagnosis of Autism, with early language needs?
☐ **Yes** ☐ **No**

Select Service:

☐ **Behavior Assessment**: Appropriate for anyone of any age who is in need of behavioral services including young children at-risk, or diagnosed with, Autism needing Early Intensive Behavior Intervention (EIBT).

Behavior Assessment: Vendor #**PT1359** Service Code **048**
Sub-Code: **EVAL** Hours: **10 Total**
Please email complete referral packet to: ClientServices@Holdsambeck.com

☐ **16-Hour Online Group Parent Training, by Behavioral Consultation**

Vendor #: **PT1043** Service Code: **102**
Sub-Code: 16-Hour Online Group Parent Training- **1 Unit**
Please email face sheet, including email address, to: BehavioralConsultation@gmail.com