

Therapeutic Behavioral Services (TBS) Termination Report

NAME / MRN _____

TBS Agency

TBS Specialist/Coach

Point Person

Date of opening:

**Date TBS
 Plan Approved:**

Date of closing:

Reason for Termination:

- Sufficient progress to terminate
- Some progress; TBS no longer appropriate
- No progress made
- Other:

Residence/Placement: Immediate Family Extended Family Foster Home STRTP

Other: _____

| | |
|---|--|
| Total number of placement changes during TBS: | |
| Total number of 5150s or hospitalizations: | |
| Total number of psychiatric emergency room visits without hospitalization: | |

Additional information:

Services/supports that will continue after TBS terminates:

Target Behavior:

- Behavioral goal achieved
- Progress made
- No progress
- Regression

Measurable Goal:

Summary of progress:

[Empty text box for Summary of progress]

Replacement behaviors and interventions:

[Empty text box for Replacement behaviors and interventions]

Collaboration:

[Empty text box for Collaboration]

NAME / MRN

Barriers to success:

Justification for termination:

Other service recommendations:

SIGNATURES

TBS Agency

TBS Specialist Signature

Print Name/Licensure/Designation

Date

TBS Clinical Supervisor Signature

Print Name/Licensure/Designation

Date