

Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Beneficiary Name: _____ Date of Birth: ____/____/____ M F
 Medi-Cal # (CIN): _____ Current Eligibility: Yes No Language/cultural needs: _____
 Address: _____ City: _____ Zip: _____ Phone: (____) _____
 Caregiver/Guardian: _____ Phone: (____) _____
 Behavioral Health Diagnosis 1) _____ 2) _____ 3) _____

Is provisional diagnosis/diagnosis an included diagnosis for MHP services Yes No Unsure

Documents Included: **Required Release of Info completed** MD notes H&P Assessment Other: _____

Primary Care Provider _____ Phone: (____) _____

List A (check all that currently apply)	List B (Check all that currently apply)	List C
<input type="checkbox"/> Persistent mental health symptoms & impairments after psychiatric consult and 2 or more medication trials in past 6 months <input type="checkbox"/> Co-morbid mental health and serious health conditions (specify below) <input type="checkbox"/> Behavior problems (aggressive/assaultive/self-destructive/extreme isolation) (specify below) <input type="checkbox"/> 3+ ED visits or 911 calls in past year <input type="checkbox"/> Significant current life stressors [e.g. homelessness, domestic violence, recent loss] (specify below) <input type="checkbox"/> Hx of trauma/PTSD that is impacting current functioning** <input type="checkbox"/> Non-minor dependent <input type="checkbox"/> May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21 only)	<input type="checkbox"/> 2+ in-patient psychiatric hospitalizations within past 18 months <input type="checkbox"/> Functionally significant paranoia, delusions, hallucinations** <input type="checkbox"/> Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year (specify below) <input type="checkbox"/> Transitional Age Youth with acute psychotic episode <input type="checkbox"/> Eating disorder with related medical complications <input type="checkbox"/> Personality disorder with significant functional impairment** <input type="checkbox"/> Significant functional impairment (not listed above) due to a mental health condition**	<input type="checkbox"/> Drug or alcohol addiction and failed SBI (screening & brief intervention at primary care)

Referral Algorithm		
1	Remains in PCP care with Beacon consult or therapy only	<input type="checkbox"/> 1-2 in List A and none in List B
2	Refer to Beacon Health Strategies (eFax (866) 422-3413)	<input type="checkbox"/> 3 in list A (2 if ages 18-21) and none in list B OR <input type="checkbox"/> Diagnosis excluded from county MHP
3	Refer to County Mental Health Plan for assessment (Fax – 510-346-1083)	<input type="checkbox"/> 4 or more in list A (3 or more if ages 18-21) OR <input type="checkbox"/> 1 or more in list B
4	Refer to County Alcohol & Drug Program (1-800-491-9099)	<input type="checkbox"/> 1 from list C

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type PCP MFT/LCSW ARNP Psychiatrist Other _____

Requested service Outpatient therapy Medication management Assessment for Specialty Mental Health Services

Pertinent Current/Past Information (**Please specify current functional impairments in a core area of life due to the condition(s) checked) :

Current symptoms and functional impairments: _____

Brief Patient history: _____

Name and Title* (Print): _____ Signature: _____ Date: _____

*Licensed LPHA, MD, DO, NP, CNS, PA

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____