

**Child 6 – 17 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary**

**MEMBER INFO**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  M  F

Medi-Cal # (CIN): \_\_\_\_\_ Current Eligibility: \_\_\_\_\_ Language/cultural requirements: \_\_\_\_\_

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 consent completed**  MD notes  H&P  Assessment  Other: \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

List A (check all that apply)	List B (Check all that apply)	List C
<input type="checkbox"/> Impulsivity/hyperactivity <input type="checkbox"/> Trauma/recent loss <input type="checkbox"/> Withdrawn/Isolative <input type="checkbox"/> Mild-moderate depression/anxiety <input type="checkbox"/> Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) <input type="checkbox"/> Significant family stressors * <input type="checkbox"/> CPS report in the last 6 months <input type="checkbox"/> Excessive truancy or failing school <input type="checkbox"/> Difficulty developing and sustaining peer relationships <input type="checkbox"/> Eating disorder without medical complications <input type="checkbox"/> Court dependent or ward of court <input type="checkbox"/> May not progress developmentally as individually appropriate without mental health intervention	<input type="checkbox"/> 1 or more psychiatric hospitalization(s) in past year <input type="checkbox"/> Suicidal/homicidal preoccupations or behaviors in past year <input type="checkbox"/> Self-injurious behaviors <input type="checkbox"/> Paranoia, delusions, hallucinations <input type="checkbox"/> Currently in out-of-home foster care placement <input type="checkbox"/> Juvenile probation supervision with current placement order <input type="checkbox"/> Functionally significant depression/anxiety <input type="checkbox"/> Eating disorder with medical complications <input type="checkbox"/> At risk of losing home or school placement due to mental health issues	<input type="checkbox"/> Substance abuse

\* **Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

Referral Algorithm	
1 Remains in <b>PCP care</b> with Beacon consult or therapy only	<input type="checkbox"/> 1 in List A and none in List B
2 Refer to <b>Beacon Health Strategies</b> (eFax (866) 422-3413)	<input type="checkbox"/> 2 in list A and none in List B OR <input type="checkbox"/> Diagnosis excluded from county MHP
3 Refer to <b>County Mental Health Plan</b> for assessment	<input type="checkbox"/> 3 or more in List A OR <input type="checkbox"/> 1 or more in List B
4 Refer to <b>County program</b> or community resources	<input type="checkbox"/> 1 in 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:**

Current symptoms and impairments: \_\_\_\_\_

Brief Patient history: \_\_\_\_\_

Name and Title(Print:): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Receiving Clinician Use ONLY**

Assigned Case Manager/MD/Therapist Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date communicated assessment outcome with referral source: \_\_\_\_\_