Child 0 - 5 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)
☐ Impulsivity/hyperactivity	☐ Significant Parent/Child attachment concerns
☐ Withdrawn/Isolative	☐ Child age 0-3 with at least 2 items from List A
☐ Mild-moderate depression/anxiety	☐ Aggression and/or frequent tantrums
☐ Excessive crying; difficult to soothe	☐ Neglect/Abuse
☐ Significant family stressors *	☐ Self-Harm: frequent head banging/risky behavior
☐ CPS report in the last 6 months	☐ Trauma
☐ Limited receptive and expressive communication skills	☐ Currently in out-of-home foster care placement
☐ Sleep Concerns: difficulty falling asleep, night waking, nightmares	☐ At risk of losing home, child care or preschool placement due to mental health issue
☐ Peer relationship issues - little enjoyment or interest in peers; self-isolating; frequent conflict with peers	☐ Separation from/loss of primary caregiver
☐ Feeding/elimination difficulties	
☐ Learning Difficulties	
☐ Sexualized Behaviors	
☐ Serious medical issues/other disabilities	

*** 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 **PCP care** with Beacon consult or therapy only	☐1 in List A and none in List B
2	Refer to **Beacon Health Strategies**(eFax (866) 422-3413)	☐2 in list A and none in List B OR ☐Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment	☐ 3 or more in List A OR ☐1 or more in List B

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: _____

_____

For Receiving Clinician Use ONLY

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

Date communicated assessment outcome with referral source: _____