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
☐ Impulsivity/hyperactivity ☐ Trauma/recent loss ☐ Withdrawn/Isolative ☐ Mild-moderate depression/anxiety ☐ Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) ☐ Significant family stressors * ☐ CPS report in the last 6 months ☐ Excessive truancy or failing school ☐ Difficulty developing and sustaining peer relationships ☐ Eating disorder without medical complications ☐ Court dependent or ward of court ☐ May not progress developmentally as individually appropriate without mental health intervention	☐ 1 or more psychiatric hospitalization(s) in past year ☐ Suicidal/homicidal preoccupations or behaviors in past year ☐ Self-injurious behaviors ☐ Paranoia, delusions, hallucinations ☐ Currently in out-of-home foster care placement ☐ Juvenile probation supervision with current placement order ☐ Functionally significant depression/anxiety ☐ Eating disorder with medical complications ☐ At risk of losing home or school placement due to mental health issues	☐ 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 **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
4	Refer to **County program** or community resources	☐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: _____