Adult 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
☐ Persistent symptoms & impairments after 2 recent medication trials ☐ Multiple co-morbid health and mental health conditions ☐ Behavior problems (aggressive/self-destructive/assaultive/extreme isolation) ☐ 3+ excessive ED visits or 911 calls in past year ☐ Bipolar disorder or manic episode ☐ Trauma/recent loss/significant life stressors (e.g. homelessness, domestic violence) ☐ Mild to moderate depression /anxiety ☐ Non-minor dependent	☐ 2+ psychiatric hospitalizations within 18 months ☐ Functionally significant paranoia, delusions, hallucinations ☐ 3+ criminal justice mental health episodes in past year ☐ Suicidal/Homicidal preoccupation or behavior in past year ☐ Transitional Age Youth with acute psychotic episode ☐ Significant functional impairment due to a mental condition (e.g. WHODAS score) ☐ Eating disorder with medical complications ☐ Personality disorder with significant functional impairment ☐ Seriously significant depression/anxiety ☐ Self-injurious behaviors	☐ 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	☐1-2 in List A and none in List B
2	Refer to **Beacon Health Strategies**(eFax (866) 422-3413)	☐3 in list A and none in list B OR ☐Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment	☐ 4 or more in list A OR ☐1 or more in list B
4	Refer to County Alcohol & Drug Program	☐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:

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: _____