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
☐ Persistent mental health symptoms & impairments after psychiatric consult and 2 or more medication trials in past 6 months ☐ Co-morbid mental health and serious health conditions (specify below) ☐ Behavior problems (aggressive/assaultive/self-destructive/extreme isolation) (specify below) ☐ 3+ ED visits or 911 calls in past year ☐ Significant current life stressors [e.g. homelessness, domestic violence, recent loss] (specify below) ☐ Hx of trauma/PTSD that is impacting current functioning** ☐ Non-minor dependent ☐ May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21only)	☐ 2+ in-patient psychiatric hospitalizations within past 18 months ☐ Functionally significant paranoia, delusions, hallucinations** ☐ Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year (specify below) ☐ Transitional Age Youth with acute psychotic episode ☐ Eating disorder with related medical complications ☐ Personality disorder with significant functional impairment** ☐ Significant functional impairment (not listed above) due to a mental health condition**	☐ 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 (2 if ages 18-21)and none in list B OR ☐Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment (Fax – 510-346-1083)	☐ 4 or more in list A (3 or more if ages 18-21) OR ☐1 or more in list B
4	Refer to County Alcohol & Drug Program (1-800-491-9099)	☐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: _____