

Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Last Name: _____ First Name: _____ DOB: _____ Female Male Other
 Medi-Cal # (CIN): _____ Current Eligibility: _____ (Specify Other): _____
 Language/Cultural Requirements (client or caregiver): _____
 Address: _____ City: _____ Zip: _____ Phone: _____
 Caregiver/Guardian: _____ Phone: _____
 Referring Clinician: _____ Phone: _____
 Primary Care Provider: _____ Phone: _____
 Behavioral Health Diagnosis: (1) _____ (2) _____ (3) _____
 Docs Included w/Referral: **Required Consent Completed** MD Notes H&P Assessment Other: _____
 Desired behavioral health clinician/provider/program, if any: _____

Reason For Referral		
<input type="checkbox"/> Behavior problems (aggressive/assaultive/self-injurious) <input type="checkbox"/> Trauma/recent loss/significant life stressors <input type="checkbox"/> Homelessness/housing instability resulting from a mental health condition <input type="checkbox"/> Depression/anxiety <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Multiple co-morbid health and mental health conditions <input type="checkbox"/> Persistent symptoms & impairments after 2 recent medication trials	<input type="checkbox"/> 2 or more psychiatric hospitalizations within 12 months <input type="checkbox"/> Functionally significant, non-substance induced paranoia, delusions, hallucinations, mania <input type="checkbox"/> Current diagnosis of personality disorder with significant functional impairment <input type="checkbox"/> Suicidal/homicidal preoccupation or behavior in past year <input type="checkbox"/> Transitional age youth with prodromal psychotic symptoms <input type="checkbox"/> Eating disorder with medical complications	<input type="checkbox"/> Substance use (primary) or failed SBI screening & brief intervention at primary care level

How to submit referral to the appropriate agencies:	
Referral to Beacon Health Options for mild-moderate level of care	Fax 877.321.1787 or email Medi-Cal.Referral@beaconhealthoptions.com
Referral to Ventura County Behavioral Health for moderate to severe level of care	Via E-Referral if available. If not, email to star@ventura.org or fax to 805.981.9268 STAR Access Line: 866.998.2243
Referral to Ventura County Behavioral Health Substance Use Services	Call Access Line at 844.385.9200 or send this referral form to SUDServices@ventura.org

Pertinent Current/Past Information:
 Current symptoms and impairments: _____

 Brief psychiatric and substance use history: _____

 Brief medical history: _____

 Current medication(s) & dosage: _____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone (_____) _____
 Date communicated assessment outcome with referral source: _____