

Child 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"/> Impulsivity/hyperactivity/inattention <input type="checkbox"/> Self-injurious behaviors <input type="checkbox"/> Depression/anxiety <input type="checkbox"/> Behavior problems (aggressive/assaultive/bullying/oppositional) <input type="checkbox"/> Residential instability	<input type="checkbox"/> Trauma/recent loss <input type="checkbox"/> Juvenile justice involvement <input type="checkbox"/> Child welfare involvement If yes, Social Worker contact: _____ _____ <input type="checkbox"/> Homelessness	<input type="checkbox"/> 1 or more psychiatric hospitalization(s) in past 12 months <input type="checkbox"/> Excessive truancy or failing school resulting from a mental health condition <input type="checkbox"/> Suicidal/homicidal preoccupations or behaviors in the past 12 months <input type="checkbox"/> Non-substance induced paranoia, delusions, hallucinations, mania	<input type="checkbox"/> Substance use (primary)

Pertinent Current/Past Information:

Current symptoms and impairments: _____

 Brief psychiatric and substance use history: _____

 Brief medical history: _____

 Current medication(s) & dosage: _____

How to submit referral to the appropriate agencies:	
Referral to Beacon Health Options for mild to 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

For Receiving Clinician Use ONLY

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