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		
☐ Behavior problems (aggressive/assaultive/self-injurious) ☐ Trauma/recent loss/significant life stressors ☐ Homelessness/housing instability resulting from a mental health condition ☐ Depression/anxiety ☐ Bipolar disorder ☐ Multiple co-morbid health and mental health conditions ☐ Persistent symptoms & impairments after 2 recent medication trials	☐ 2 or more psychiatric hospitalizations within 12 months ☐ Functionally significant, non-substance induced paranoia, delusions, hallucinations, mania ☐ Current diagnosis of personality disorder with significant functional impairment ☐ Suicidal/homicidal preoccupation or behavior in past year ☐ Transitional age youth with prodromal psychotic symptoms ☐ Eating disorder with medical complications	☐ 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: _____