Referral Date: _____

Mental Health Level of Care Screening Tool

PCP Information

Primary Care Provider: _____ Health Network: _____

Address: _____ City: _____ ZIP: _____ Phone: (_____) _____

Member Information

Member Name: _____ Date of Birth: ____/____/____ M☐ F☐

Medi-Cal Number (CIN): _____ Language: _____ Phone: (_____) _____

Mild to Moderate Impairment in the Following Areas of Functioning Due to a Mental Health Condition:

- ☐ At risk of losing job, falls behind at work or school at times, or some difficulty caring for family and home
- ☐ Has had some contact with the police or one or more arrests
- ☐ Few friends, or has conflict or infrequent contact with friends
- ☐ Occasional disagreement with family or strained relationships and/or infrequent contacts with family
- ☐ Able to identify or engage in very limited acceptable/appropriate activities
- ☐ Occasionally fails to maintain personal health and hygiene
- ☐ May require some assistance from others at times to live independently or occasionally dependent on others for shelter, at risk of becoming homeless
- ☐ Thoughts about harming self or others on a few occasions or thought s/he might be better off dead
- ☐ Some concerns the child may not be progressing developmentally as individually appropriate (21 and under)
- ☐ Other: _____

Severe Impairment in the Following Areas of Functioning Due to a Mental Health Condition:

- ☐ Not seeking employment, unable to keep job or stay in school, or failing school, or unable to care for family and home
- ☐ Frequent problems with the law
- ☐ Isolated, no friends, or avoids friends s/he has
- ☐ Avoided by family, frequent conflict with family and/or neglects family
- ☐ Unable to identify or engage in acceptable/appropriate activities
- ☐ Fails to maintain personal health and hygiene
- ☐ Dependent on others for shelter, homeless
- ☐ Frequent thoughts of committing suicide and/or harming others
- ☐ Recent psychiatric hospitalization
- ☐ A reasonable probability the child is not progressing developmentally as individually appropriate (21 and under)
- ☐ Other: _____

PCP Request

Referral for CalOptima Behavioral Health Services: Refer members with MILD to MODERATE level of functional impairment for therapy or medication management when their needs are outside the PCP scope of practice, OR

Referral for Orange County Specialty Mental Health Services: Refer members with SEVERE level of functional impairment to county mental health services.

Referral for Substance Use Disorder Services: refer members with substance use disorders and SBI referrals.

PCP Decision Support: Request a telephone consultation with a Beacon psychiatrist to provide decision support related to member diagnostic and medication clarification or other clinical decision supports.

Motivation for Services (check all that apply)

- ☐ Member (or guardian) has been informed of referral to Beacon Health Strategies
- ☐ Member wants services for self (or dependent)
- ☐ If applicable, member has completed a PHQ-2/PHQ-9. Score: _____

Referral Date: _____

Instructions for Referrals:

Referral for CalOptima Behavioral Health Services: Refer members with **MILD** to **MODERATE** level of functional impairment for therapy or medication management when their needs are outside the PCP scope of practice. Call CalOptima Behavioral Health at **855-877-3885**.
Note: For exchange of information **back to the PCP,** include signed member Consent to Release of Information. *Fax:* ***866-422-3413***

Referral for Orange County Specialty Mental Health Services: Refer members with **SEVERE** level of functional impairment to county mental health services. Call the Orange County Mental Health Plan Access Line at 800-723-8641.
Note: For exchange of information **back to the PCP**, include signed member Consent to Release of Information. *Fax:* ***866-422-3413***

Referral for Substance Use Disorder Services: Refer members with substance use disorders and SBI referrals. Call CalOptima Behavioral Health at **855-877-3885**.

PCP Decision Support: Request a telephone consultation with a Beacon psychiatrist to provide decision support related member diagnostic and medication clarification or other clinical decision supports. Include medication list and last two PCP progress notes for psychiatrist review **before** phone consult with PCP. Fax: **866-422-341**; Email: **Medi-CalReferral@beaconhs.com**