

Child 0 - 5 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ M F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

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 consent completed** MD notes H&P Assessment Other: _____

Primary Care Provider _____ Phone: (____) _____

List A (check all that apply)	List B (Check all that apply)
<input type="checkbox"/> Impulsivity/hyperactivity <input type="checkbox"/> Withdrawn/Isolative <input type="checkbox"/> Mild-moderate depression/anxiety <input type="checkbox"/> Excessive crying; difficult to soothe <input type="checkbox"/> Significant family stressors * <input type="checkbox"/> CPS report in the last 6 months <input type="checkbox"/> Limited receptive and expressive communication skills <input type="checkbox"/> Sleep Concerns: difficulty falling asleep, night waking, nightmares <input type="checkbox"/> Peer relationship issues - little enjoyment or interest in peers; self-isolating; frequent conflict with peers <input type="checkbox"/> Feeding/elimination difficulties <input type="checkbox"/> Learning Difficulties <input type="checkbox"/> Sexualized Behaviors <input type="checkbox"/> Serious medical issues/other disabilities <input type="checkbox"/> May not progress developmentally as individually appropriate without mental health intervention	<input type="checkbox"/> Significant Parent/Child attachment concerns <input type="checkbox"/> Child age 0-3 with at least 2 items from List A <input type="checkbox"/> Aggression and/or frequent tantrums <input type="checkbox"/> Neglect/Abuse <input type="checkbox"/> Self-Harm: frequent head banging/risky behavior <input type="checkbox"/> Trauma <input type="checkbox"/> Currently in out-of-home foster care placement <input type="checkbox"/> At risk of losing home, child care or preschool placement due to mental health issue <input type="checkbox"/> Separation from/loss of primary caregiver

* **Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

Referral Algorithm	
1	Remains in PCP care with Beacon consult or therapy only <input type="checkbox"/> 1 in List A and none in List B
2	Refer to Beacon Health Strategies (eFax (866) 422-3413) <input type="checkbox"/> 2 in list A and none in List B OR <input type="checkbox"/> Diagnosis excluded from county MHP
3	Refer to County Mental Health Plan for assessment <input type="checkbox"/> 3 or more in List A OR <input type="checkbox"/> 1 or more in List B

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:

Current symptoms and impairments: _____

Brief Patient history: _____

Name and Title(Print): _____ Signature: _____ Date: _____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____