

Child 6 – 17 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)	List C
<input type="checkbox"/> Impulsivity/hyperactivity <input type="checkbox"/> Trauma/recent loss <input type="checkbox"/> Withdrawn/Isolative <input type="checkbox"/> Mild-moderate depression/anxiety <input type="checkbox"/> Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) <input type="checkbox"/> Significant family stressors * <input type="checkbox"/> CPS report in the last 6 months <input type="checkbox"/> Excessive truancy or failing school <input type="checkbox"/> Difficulty developing and sustaining peer relationships <input type="checkbox"/> Eating disorder without medical complications <input type="checkbox"/> Court dependent or ward of court <input type="checkbox"/> May not progress developmentally as individually appropriate without mental health intervention	<input type="checkbox"/> 1 or more psychiatric hospitalization(s) in past year <input type="checkbox"/> Suicidal/homicidal preoccupations or behaviors in past year <input type="checkbox"/> Self-injurious behaviors <input type="checkbox"/> Paranoia, delusions, hallucinations <input type="checkbox"/> Currently in out-of-home foster care placement <input type="checkbox"/> Juvenile probation supervision with current placement order <input type="checkbox"/> Functionally significant depression/anxiety <input type="checkbox"/> Eating disorder with medical complications <input type="checkbox"/> At risk of losing home or school placement due to mental health issues	<input type="checkbox"/> Substance abuse

* **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
4	Refer to County program or community resources	<input type="checkbox"/> 1 in list C

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: _____