Gold Coast Health Plan[SM]
A Public Entity

BEACON HEALTH OPTIONS
PRIMARY CARE PROVIDER (PCP) REFERRAL FORM

Date: ______________________ PCP Name: ________________________________ PCP Phone #: ________________________

Member Name: ____________________________________ Member ID #: ________________________ DOB: ________________

Language: ___________________ Phone #'s: ____

PCP REQUEST (one request per referral form)

☐ **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
** Include medication list and last 2 PCP Notes for Psychiatrist review before phone consult with PCP
Fax: **866.422.3413** OR secure email: medi-calreferral@beaconhs.com

☐ **Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Beacon's network of providers when their needs are outside the PCP scope of practice. Beacon can coordinate member care with county mental health
** For exchange of information back to the PCP, include signed member Consent to Release of Information.
Fax: **866.422.3413** OR secure email: medi-calreferral@beaconhs.com

☐ **Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with established diagnosis of Autism Spectrum Disorder (ASD)
** Include Progress Note with diagnosis of ASD and physician order requesting ABA services
Fax to: **800.596.2712**

☐ **Referral for Care Management:** Local behavioral health care coordination services to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community support services
** For exchange of information back to the PCP, include signed member Consent to Release of Information
Fax: **855.371.3947** OR secure email: MC_GCHP@beaconhs.com

REQUEST REASON: (check all that apply):

☐ Depression
☐ Isolation
☐ Trauma
☐ Substance use type: ____________________________________
☐ Anxiety
☐ Delusional
☐ Violence/Abuse
☐ Poor self-care due to mental health
☐ Auditory/Visual hallucinations
☐ Cognitively Impaired (or cognitive impairment)
☐ Other BH Diagnosis: ________________________________

☐ Other BH symptoms:____

Medical Diagnosis: ____

Medications (list below or send medication list with this form): ____

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Other known barriers to member adherence to medical care: ____

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MOTIVATION FOR SERVICES (check all that apply):

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