Santa Clara Family Health Plan

Behavioral Health Referral Form

Behavioral Health
Email: BehavioralHealthHelpDesk@scfhp.com
Phone: **1-408-874-1984**
Fax: **1-408-874-1427**

This Behavioral Health Referral Form can be submitted on behalf of any Santa Clara Family Health Plan (SCFHP) member who would benefit from mental health services, substance-use treatment services, or Behavioral Health Case Management. This form should not be used for urgent needs. Please return the completed form via SECURE email or fax. Allow up to three (3) business days for processing by SCFHP.

Member information		
First name and Last name:	SCFHP ID:	Date of Birth:
Preferred spoken language:	Primary phone:	

Reason for referral *(check all that apply)***:**

- ☐ Need for Behavioral Health Case Management
- ☐ Need for mental health services
- ☐ Need for substance-use treatment services
- ☐ Recent hospitalization for mental health or substance-use disorder - Date of discharge:
- ☐ New mental health or substance-use disorder diagnosis - Date of diagnosis:
- ☐ Other:

Relevant Diagnosis *(if any)*

DSM Code:	**Description:**

Attached applicable supporting documentation *(if any)***:**

- ☐ Face sheet
- ☐ DHCS Transition of Care Tool
- ☐ History
- ☐ Progress Notes
- ☐ Medication list
- ☐ Treatment (Tx) plan
- ☐ Assessment
- ☐ Other:

Additional referral information

Referring provider/agency information	
Name/agency:	Date:
Phone:	Email:

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