Gold Coast Health Plan℠
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CARELON BEHAVIORAL HEALTH / GOLD COAST HEALTH PLAN
BEHAVIORAL HEALTH CARE MANAGEMENT REFERRAL FORM

Referral Date: _____ **Member Name:** _____ **Medi-Cal CIN ID#:** _____

DOB: _____ **Parent / Guardian Name:** _____ **Preferred Language:** _____

Phone #: _____ (home) _____ (parent / guardian's cell) _____ (member's cell)

Member notified of this referral ☐ Yes ☐ No **Parent / guardian notified of this referral** ☐ Yes ☐ No

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If the member is a minor 12 and older, who is requesting MH care management and services?

☐ Member only (parent / guardian is unaware) ☐ Parent / guardian only ☐ Both member and parent / guardian

Does the minor 12 and older have the capacity to consent to services? ☐ Yes ☐ No

If no, please explain _____

Best day / time to reach the member: _____

Best day and time to reach the parent / guardian: _____

PCP Clinic / Agency: _____ **Name of PCP:** _____

PCP Phone #: _____

REFERRAL SOURCE:

☐ **Health Plan** ☐ **PCP** ☐ **Behavioral Health Provider** ☐ **Specialty Provider** ☐ **Community Partner** ☐ **Hospital**

Referring Clinic / Agency / Location: _____ ***Referring Provider:*** _____

Email: _____ ***Contact Phone #:*** _____ ***Fax #:*** _____

REQUESTED REFERRAL

☐ **Referral for Care Management:** Local behavioral health care coordination services to link members to mental health providers, engage members with a history of non-compliance and/or link them to community support services, and assist with coordination between multiple agencies.

Requested Services: ☐ Individual / Group Therapy ☐ Family Therapy ☐ Medication Management ☐ Other:_____

REFERRAL REASON (check all that apply):

☐ Depression / Anxiety
☐ Poor self-care due to mental health
☐ Psychosis (auditory / visual hallucinations, delusional)
☐ PTSD / Trauma
☐ Violence / Aggressive Behavior
☐ Difficult / Unable to Complete ADLs
☐ Difficult / Unable to go to Work / School
☐ Perinatal Depression and/or Anxiety
☐ Suicidal or Homicidal Ideation: If yes, Current ☐ History ☐
☐ Response Given on HRA: _____
☐ Difficulties Maintaining Relationships
☐ Gender Identity
☐ Legal, Child or Elder Abuse
☐ Adverse Childhood Experiences (ACEs): Score _____
☐ Chronic Pain
☐ Other: _____

Step-down from county SMHS: Yes ☐ No ☐

Substance Use: If yes, Current ☐ History ☐ Substance Use (type): _____

Mental health and medical diagnoses: _____

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

_____

Additional Information: _____

Member Motivation for Services:

☐ Member wants services for self (or dependent).
☐ Member is unsure or ambivalent about services for self (or dependent).
☐ Member does not want services or does not believe they are needed.
☐ Member has not been informed of this referral to Carelon Behavioral Health.

Please complete the form as fully as possible.
Send referral via secure email: GCHP.ColocatedTeam@carelon.com or fax to: **1-855-371-3947**

For members 12 and older, in certain situations under privacy law AB1184, a written ROI may be required to share sensitive information with anyone, including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.