Gold Coast Health Plan℠
A Public Entity

carelon

Integrity • Accountability • Collaboration • Trust • Respect

CARELON BEHAVIORAL HEALTH / GOLD COAST HEALTH PLAN
PRIMARY CARE PROVIDER (PCP) REFERRAL FORM

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

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

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

Does the minor 12 and older have the capacity to give consent? ☐ Yes ☐ No If no, please explain: _____

Best day / time to reach the member: _____ **Best day / time to reach the parent / guardian:** _____

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

☐ **Please check to confirm member eligibility was verified.**

PCP REQUEST (one request per referral form)

☐ **PCP Decision Support:** Obtain a mental health educational conversation with a Carelon Behavioral Health psychiatrist about psychiatric diagnoses / medications. Contact the National Peer Advisor line: **Office Hours**: 6 a.m. – 5 p.m. PST Monday – Friday.
Please call phone number: 1-877-241-5575

☐ **Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Carelon Behavioral Health's network of providers when their needs are outside the PCP's scope of practice. Carelon Behavioral Health can coordinate member care with county mental health.
Fax: **1-877-321-1787** OR secure email: medi-cal.referral@carelon.com

☐ **Behavioral Health Treatment (BHT) / Applied Behavioral Analysis (ABA) Services:** Specialty services for **youth under 21 years old** with an established diagnosis of Autism Spectrum Disorder (ASD).
** Include a Progress Note with the diagnosis of ASD and physician order requesting ABA services.
Fax: **1-877-321-1776** OR secure email: ASGCare.Managers@carelon.com

REQUEST REASON (check all that apply):

Symptoms:

☐ Depression
☐ Poor self-care due to mental health
☐ Psychosis (auditory / visual hallucinations, delusional)
☐ Adverse Childhood Experiences (ACEs)
☐ Substance use type: _____
☐ Perinatal depression / anxiety
☐ Violence / aggressive behavior
☐ Psychological testing
☐ Neuropsychological testing
☐ PTSD / Trauma
☐ Abuse / CPS
☐ Chronic Pain
☐ Anxiety

☐ Other behavioral health symptoms: _____

Impairments:

☐ Difficult / Unable to complete ADLs
☐ Difficult / Unable to go to work / school
☐ Other: _____
☐ Difficulties maintaining relationships
☐ Legal / CPS

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

MOTIVATION FOR SERVICES (check all that apply):

☐ Member (or guardian) has been informed of referral to Carelon Behavioral Health
☐ Member wants services for self (or dependent)
☐ Member is unsure or ambivalent about services for self (or dependent)
☐ If applicable, the Patient has completed a PHQ-2 / PHQ-9, Score _____

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 involved in the member's care.