Carelon Health Options/Central California Alliance for Health

Primary Care Provider (PCP) Referral Form

Date: _____ **PCP Name**: _____ **Phone #**: _____
Referring Provider:_____**Name of Clinic/Agency:** _____
Member Name: _____ **Medi-Cal CIN#:** _____ **DOB:** _____
Language: _____ **Phone #'s:** _____ **Best day/time to contact:** _____

To Receive a Confirmation of This referral's outcome, please check the box below noting preferred method and contact details:

☐ **Email address:**_____☐**Fax Number:** _____

PCP Request (one request per referral form)

☐**PCP Decision Support: Request a telephone consultation** with a Carelon psychiatrist to provide decision support related to member diagnostic and medication clarification or other clinical decision supports.
**Include medication list and last 2 PCP Progress Notes for Psychiatrist review before phone consult with PCP.
*Fax: **877.321.1787** OR secure email: medi-cal.referral@carelonbehavioralhealth.com*

☐**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Carelon's network of providers when their needs are outside the PCP scope of practice. Carelon can coordinate member care with county mental health.
*Fax: **877.321.1787** OR secure email: medi-cal.referral@carelonbehavioralhealth.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: **877.321.1776** OR secure email: care.managers@carelonbehavioralhealth.com*

☐**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 noncompliance and link them to community support services. *secure email: MC_CCAH@carelonbehavioralhealth.com*

☐**Referral for Psychological or Neuropsychological testing:** Refer members to psychological/neuropsychological testing via Carelon's network of providers when their needs are outside the PCP scope of practice. Carelon can coordinate member care with county mental health.
*Fax: **877.321.1787** OR secure email: medi-cal.referral@carelonbehavioralhealth.com*

Request Reason (check all that apply):

Symptoms:

☐Depression
☐Poor self-care due to mental health
☐Psychosis (auditory/visual hallucinations, delusional)
☐ Perinatal depression/anxiety
☐ Abuse/CPS
☐ Anxiety
☐ PTSD/Trauma
☐ Chronic pain
☐ Psychological testing
☐ Violence/Aggressive bx
☐ Neuropsychological testing

☐Substance use type:_____☐Other BH symptoms: _____

Impairments:

☐ Difficult/Unable to complete ADLs ☐Difficulties maintaining relationships ☐Legal/CPS
☐ Difficult/Unable to go to work/school ☐Other:_____
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 Health Options
☐ Member wants services for self (or dependent)
☐ If applicable, Patient has completed a PHQ-2/PHQ-9. Score _____