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 address: _____

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

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 capacity to give 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#:*** _____

☐ **Referral for Care Management:** Local behavioral health care coordination services to: link members to mental health providers, engage members with 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: _____

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

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