SAN FRANCISCO HEALTH PLAN
Here for you

Beacon Health Options
San Francisco Health Plan
Care Management Referral Form

beacon health options

Referral Date:_____ Member Name:_____ Member ID#:_____

DOB: _____ Member Phone #:_____(home) _____(cell)

Member's Preferred Language:_____ ☐ **Please check here** to confirm member eligibility was verified

REFERRAL SOURCE:

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

Referring Provider: _____

Submitted by:_____ ***Contact Phone #:***_____

Facility/Clinic_____ ***Fax #***4_____

Email address for confirmation of referral outcome: _____

Requested Referral

☐**Referral for Care Management:** Local behavioral health care coordination services to: link members to mental health providers, support transition between levels of care (Beacon to County or visa versa), engage members with history of non-compliance and/or link them to community support services (food, shelter, transportation), and assist with coordination between multiple agencies.
Fax referral form to: ***855-371-8113*** *OR secure email:* **MC_SFHP@Beaconhealthoptions.com**

Request Reason (check all that apply):

Symptoms:

☐Depression/Anxiety
☐Poor self-care due to mental health
☐Psychosis (auditory/visual hallucinations, delusional)
☐PTSD/Trauma
☐Violence/Aggressive Behavior
☐Substance use type: _____
☐Other BH symptoms: _____
☐Abuse/CPS
☐Perinatal depression and/or anxiety
☐Suicidal Ideation
☐Homicidal Ideation
Chronic Pain

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):

_____

_____