Beacon Health Strategies
Primary Care Provider (PCP) Referral Form

Date: _____ **PCP Name**: _____ **Phone #**: _____

Member Name: _____ **Member ID #:** _____ **DOB:** _____

Language:_____ **Phone #'s:**_____ ; _____

PCP Request (one request per referral form)

☐ **PCP Decision Support: Request a telephone consultation** with a Beacon 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:* ***866.422.3413* *OR secure email:* medi-calreferral@beaconhs.com

☐ **Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Beacon's network of providers when their needs are outside the PCP scope of practice. Beacon can coordinate member care with county mental health.
** For exchange of information *back to the PCP*, include signed member Consent to Release of Information. *Fax:* ***866.422.3413*** *OR secure email:* medi-calreferral@beaconhs.com

☐ **Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old.

Please check one of the following boxes.

☐ I am submitting a Diagnostic Evaluation Form (attached) indicating diagnosis, problem behaviors and recommendation for BHT/ABA.

☐ I am recommending a referral for Diagnostic Evaluation for possible ABA recommendations.

Fax form to: ***800.596.2712 OR*** *secure email: care.managers@beaconhealthoptions.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 non-compliance and link them to community support services.
** For exchange of information *back to the PCP*, include signed member Consent to Release of Information. *Fax: 855-371-8113 OR email:* MC_SFHP@Beaconhs.com

Request Reason (check all that apply):

☐ Depression ☐ Anxiety ☐ Other BH Diagnosis: _____
☐ Isolation
☐ Trauma ☐ Perinatal depression and/or anxiety ☐ Poor self-care due to mental health
☐ Violence/ Abuse ☐ Cognitively Impaired (or cognitive impairment) ☐ Auditory/Visual hallucinations
☐ Substance use type: _____

☐ Other BH symptoms: _____

Medical Diagnosis: _____

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

_____

_____

Other known barriers to member adherence to medical care: _____

_____

Motivation for Services (check all that apply):
☐ Member (or guardian) has been informed of referral to Beacon Health Strategies
☐ Member wants services for self (or dependent)
☐ If applicable, Patient has completed a PHQ-2/PHQ-9. Score _____

行為健康醫生及主診醫師共用保密資訊的授權書

會員同意公開保密資訊

本人_____特此允許_____

(會員姓名) (行為健康醫生)

及我的主診醫師_____共用有關我的物質濫用的診斷及/或治療、精神健康或病史的資

(主診醫師)

訊，不包括人類免疫缺乏病毒 (HIV) 抗體的血液檢測結果。我理解，共用資訊的目的是協助我獲得更好的護理。

本同意書自簽字日期起 90 日內有效，並且我可以隨時撤銷同意。

_____ _____

會員/監護人/授權代表 日期

_____ _____

見證人 日期

會員拒絕公開保密資訊

本人_____**不**允許 _____及我的主診醫師

(會員姓名) (行為健康醫生)

_____共用我的有關物質濫用的診斷及/或治療、

(主診醫師)

精神健康或病史的資訊，包括人類免疫缺乏病毒 (HIV) 抗體的血液檢測結果。我理解，共用資訊的目的是協助我獲得更好的護理。我還理解，我拒絕共用資訊不會影響我的保險範圍。

_____ _____

會員/監護人/授權代表 日期

_____ _____

見證人 日期

本同意書自簽字日期起 90 日內有效，並且我可以隨時撤銷同意。