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)

Parent/Guardian Name: _____ Member's Preferred Language: _____

Best time to reach member:_____

☐ Check to confirm member eligibility was verified Member notified of referral to Beacon ☐ Yes ☐ No

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

MEMBER MOTIVATION FOR SERVICES:

☐ Member wants services for self (or dependent)
☐ Member is unsure of 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 Beacon

REFERRAL SOURCE:

☐Hospital ☐Health Plan ☐ PCP ☐ Behavioral Health Provider ☐ Specialty Provider ☐ Community Partner
Referring Provider: _____ Referring Clinic/Agency: _____
Submitted by: _____ Contact Phone #: _____
Email address for confirmation of referral outcome: _____

REQUESTED REFERRAL:

☐ **Referral for Care Management:** Local behavioral health care coordination of services to: link member to mental health providers, support transition between levels of care (between Beacon and County services), or link to community support services and assist with coordination between multiple agencies.

Fax referral form to: ***855-371-8113*** *OR secure email:* **MC_SFHP@Beaconhealthoptions.com**

REQUESTED BEHAVIORAL HEALTH SERVICES:

☐ Therapy ☐ Medication Management ☐ Other

Current BH Services: _____

REQUEST REASON:

☐Depression/Anxiety
☐PTSD/Trauma
☐Psychosis (auditory/visual hallucinations, delusions)
☐Difficulty/Unable to complete ADLs
☐Violent/aggressive behavior
☐Difficulty maintaining relationships
☐Suicidal Ideation: If yes, Current ☐ History ☐
☐Homicidal Ideation
☐Perinatal Depression and/or Anxiety
☐Gender Dysphoria
☐Chronic Pain
☐Legal, Child/Elder Abuse
☐Poor self-care due to mental health
☐ Adverse Childhood Experiences (ACEs): Score _____
☐Substance Use (type)_____
☐Other Behavioral Health Symptoms _____

Medical Conditions: _____

Medications: _____

Additional Information: _____