



# 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: **877.321.1787** OR secure email: [medi-calreferral@beaconhs.com](mailto: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: **877.321.1787** OR secure email: [medi-calreferral@beaconhs.com](mailto: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](mailto: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](mailto:MC_SFHP@Beaconhs.com)

### Request Reason (check all that apply):

- Depression
- Anxiety
- Other BH Diagnosis: \_\_\_\_\_
- Isolation
- Perinatal depression and/or anxiety
- Poor self-care due to mental health
- Trauma
- Cognitively Impaired (or cognitive impairment)
- Auditory/Visual hallucinations
- Violence/ Abuse
- 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訊，  
(主診醫師)

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。**