Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

BEACON HEALTH OPTIONS/GOLD COAST HEALTH PLAN
BEHAVIORAL HEALTH CARE MANAGEMENT REFERRAL FORM

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

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

Member's Preferred Language: _____ ☐ **Please check 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 #:** _____

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: **855-371-3947** OR secure email: GCHP.ColocatedTeam@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
☐ Substance use type: _____
☐ Violence/Aggressive Behavior
☐ Abuse/CPS
☐ Suicidal Ideation
☐ Homicidal Ideation

☐ Other BH symptoms: _____

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): _____

_____

_____

_____

_____