



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:

- | | |
|---|---|
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Violence/Aggressive Behavior |
| <input type="checkbox"/> Poor self-care due to mental health | <input type="checkbox"/> Abuse/CPS |
| <input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusional) | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> PTSD/Trauma | <input type="checkbox"/> Homicidal Ideation |
| <input type="checkbox"/> Substance use type: _____ | |
| <input type="checkbox"/> Other BH symptoms: _____ | |

Impairments:

- | | |
|--|---|
| <input type="checkbox"/> Difficult/Unable to complete ADLs | <input type="checkbox"/> Difficulties maintaining relationships |
| <input type="checkbox"/> Difficult/Unable to go to work/school | <input type="checkbox"/> Legal/CPS |
| <input type="checkbox"/> Other: _____ | |

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

