Gold Coast Health Plan℠ A Public Entity

beacon health options

Integrity • Accountability • Collaboration • Trust • Respect

BEACON HEALTH OPTIONS / GOLD COAST HEALTH PLAN
PRIMARY CARE PROVIDER REFERRAL FORM

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

Referring Provider: _____

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

Member's Preferred Language: _____ **Member Phone #:** _____ (home)

☐ **Please check to confirm member eligibility was verified.** _____ (cell)

TO RECEIVE A CONFIRMATION OF THIS REFERRAL'S OUTCOME,
PLEASE CHECK THE BOX BELOW NOTING YOUR PREFERRED METHOD AND CONTACT DETAILS.

☐ Email Address: _____ ☐ Fax Number: _____

REQUESTED REFERRAL (please use separate forms for multiple referrals)

☐ **PCP Decision Support:** Request a phone call (curbside consult) with a Beacon psychiatrist for member diagnostic or prescribing support.
_Include*** med list and two PCP progress notes for psychiatrist review ***before*** phone call.

- Please note preferred date / time for consult:_____(date) _____(time)
- Best phone number to *directly* call PCP:_____

Fax form to: **1-866-422-3413** OR secure email: medi-cal.referral@beaconhealthoptions.com

☐ **Outpatient Behavioral Health Services:** Refer members interested in therapy or medication management via Beacon's network when needs are outside PCP scope. Beacon coordinates with county mental health.

Fax form to: **1-866-422-3413** OR secure email: medi-cal.referral@beaconhealthoptions.com

☐ **Behavioral Health Treatment (BHT) / Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under age 21.
_Include*** progress note with a behavioral heath diagnosis and physician order requesting ABA services.

If there is a suspected, but not yet established diagnosis, please check one or both of the following boxes.
☐ I am submitting a Diagnostic Evaluation Form (attached) indicating red flags.
☐ I am recommending a referral for Comprehensive Diagnostic Evaluation (CDE).

Fax form to: **1-800-596-2712** OR secure email: care.managers@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
☐ Violence / Aggressive Behavior
☐ Substance use type: _____
☐ Abuse / CPS
☐ Suicidal Ideation
☐ Homicidal Ideation
☐ Chronic Pain
☐ Perinatal depression and / or anxiety

☐ 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): _____

_____