Beacon Health Options – Alameda Alliance for Health
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 2 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: ***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: ***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 with diagnosis of Autism Spectrum Disorder (ASD). *****Include*** progress note with ASD Dx and physician order requesting ABA services.

If there is a suspected but not yet established ASD diagnosis, please check one or both of the following boxes.

☐ I am submitting a Diagnostic Evaluation Form (attached) indicating ASD red flags.

☐ I am recommending a referral for Comprehensive Diagnostic Evaluation (CDE)

Fax form to: ***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: _____
☐Other BH symptoms: _____
☐Abuse/CPS
☐Suicidal Ideation
☐Homicidal Ideation
☐Chronic Pain

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):

_____

_____

Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

Member Consent to Release Confidential Information

I, _____ give permission to _____
(Member Name) (Behavioral Health Provider)
and my Primary Care Physician _____ to share information about my
(Primary Care Physician)
diagnosis and / or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

Member Refusal to Release Confidential Information

I, _____ **DO NOT** give permission to _____
(Member Name) (Behavioral Health Provider)
and my Primary Care Physician _____ to share information about my
(Primary Care Physician)
diagnosis and / or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.