URGENT Behavioral Health Screening Form to Obtain Specialty Mental Health Assessment
Please complete and follow algorithm

*****If this is an emergency, please call 911** Referral Date: _____

REFERRING PROVIDER INFORMATION

Please indicate where the *Receiving Clinician* should send the disposition of the urgent appointment:

Fax number: (_____) _____ - _____ To the attention of: _____

MEMBER INFORMATION

Patient Name: _____ (Last) _____ (First) Date of Birth: ____/____/____ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (_____) _____

Caregiver/Guardian: _____ Phone: (_____) _____

Referring Clinician: _____ Phone: (_____) _____

Primary Care Provider _____ Phone: (_____) _____ Health Plan: _____

Behavioral Health Diagnoses (1) _____ (2) _____ (3) _____

Documents Included with Referral: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Desired/existing behavioral health clinician/provider/program, if any: _____

List A (check all that apply):

- ☐ Homelessness
- ☐ Still symptomatic after 2 standard psychiatric med trials
- ☐ History of bipolar disorder or manic episode
- ☐ Excessive truancy or failing school
- ☐ Substance and/or EtOH addiction and failed SBI
- ☐ Behavior problems (aggressive/self-destructive/assaultive)
- ☐ Paranoid, hearing voices, seeing things, delusional
- ☐ Excessive emergency room visits or hospitalizations
- ☐ Significant functional impairment in key roles, (e.g., work, home, self-care)

List B (check all that apply):

- ☐ >2 psychiatric hospitalizations in the past 12 months
- ☐ Suicidal/homicidal preoccupation or behaviors in past 12 months
- ☐ >2 incarcerations in past 12 months
- ☐ Diagnostic uncertainty

Referral algorithm based on checked boxes:

☐ 1-2 in list A and none in list B: **Call health plan's behavioral health network for consult**

☐ 3 or more in list A and none in list B **OR** one in both lists: **Refer to health plan's behavioral health network**

☐ 2 or more in list A and one in list B **OR** 2 or more in list B: **Refer to County Department of Mental Health at (855) 425-8141**

☐ Substance and/or EtOH addiction and failed SBI alone: **Refer to County Substance Abuse Prevention & Control at (888) 742-7900**

Pertinent Current/Past Information

Current symptoms and impairments: _____

_____

Brief MH/SUD history: _____

Brief medical history/diagnosis: _____

Current Medication(s) & Dosage: _____

For Receiving Clinician Use ONLY

Instructions: **Fax this form to the number and person indicated at the top of the form**

Disposition of urgent appointment: ☐ Attended ☐ Rescheduled ☐ Did Not Show* ☐ Declined* ☐ Unable to Accept Insurance Type*

*Referring provider to follow up with individual

Assigned Case Manager/MD/Therapist Name: _____ Phone: (_____) _____

Date disposition sent to referral source: _____/_____/_____ ☐ *Care Coordination between Providers* (MH 707) form attached

Confidential Patient Information, See CA W&I Code Section 5328

Instructions for the Screening Form

If this is an emergency situation, please call 911

Abbreviations: **H&P**: History and Physical Exam **EtOH**: Alcohol
MH/SUD: Mental Health and Substance Use Disorder **SBI**: Screening and Brief Intervention

Explanations:

- '*Current Eligibility*': Other insurance, i.e., Medicare, private, etc. **Note:** If patient is a **Cal MediConnect** member, please enter: "CMC/(Name of Health Plan)" and the CMC ID #.
- '*Caregiver/Guardian*': Parents (for minor), conservator, etc.
- '*Required consent completed*': Written consent (Authorization to Exchange Protected Health Information) or verbal consent (when screened over the phone) is required prior to releasing information to mental health and/or substance use disorder evaluator/receiving clinician (please clearly document).
- '*Desired/Existing behavioral health clinician/provider/program*': Complete this section if member/client or referral source prefers a specific program, clinician, or provider that would meet member's individual needs. If member/client is currently receiving services from a mental health program, clinician, or provider, please indicate name and contact information.
- '*Excessive ER visits or 911 calls*': Check this box if the number of visits or calls exceeds what is reasonably expected as a result of the patient's general physical and behavioral health conditions.
- '*Diagnostic uncertainty*': This section applies only when it is affecting behavioral health care planning.

Referring provider:

- If the Member/Client has an existing behavioral health clinician/provider or an open/active case in a program, please refer him/her directly to that treating source and send the written consent (or documentation of a verbal consent via phone) with the screening form to the treating source.
- For referrals to the **health plan's behavioral health network**, please send the written consent (or documentation of verbal consent via phone) with the screening form to the appropriate fax number or e-mail address and then call the phone number listed (see chart on Page 3 for contact information). **Note:** For **L.A. Care** providers with access to the **eConsult platform**, you are able to send the screening form via this platform.
- For referrals to County **Department of Mental Health** (DMH), please send the written consent (or documentation of verbal consent via phone) with the screening form to the ACCESS Urgent Appointment Line via secure email at screener@dmh.lacounty.gov, fax to **(562) 863-3971**, or eConsult and then call the DMH line at **(855) 425-8141**.
- For referrals to County **Substance Abuse Prevention & Control** (SAPC), please send the written consent (or documentation of verbal consent via phone) with the screening form to the provider referral fax at **(626) 458-7637** and then call the SAPC line at **(888) 742-7900**.

Receiving clinician:

- The "For Receiving Clinician Use ONLY" section must be completed and faxed to the number and person indicated at the top of the screening form as soon as the disposition of the initial appointment is known.
- The "Disposition of Initial Appointment" information must also be entered into the DMH Service Request Tracking System (SRTS) record.
- The completed "Authorization to Exchange PHI" accompanying the "URGENT Behavioral Health Screening Form" permits a response to the referral source without further authorization.
- Complete and return the ***Care Coordination between Providers*** **(MH 707)** form to the referring provider once the assessment has been completed. If it is determined that the individual's treatment need is better met at a different system of care/level of

care, please refer and send the MH 707 form and completed assessment documents to the appropriate system of care/level of care.

- If the care is determined to be appropriately provided by the primary care physician, contact the health plan's behavioral health network.
- In the event of a disagreement as to the appropriate system of care/level of care, please forward the case to the appropriate identified individual responsible for dispute resolution within your system of care and continue with treatment while the decision is pending.
- If the Member/Client has requested services by himself/herself without a referral, please make sure to communicate with the identified primary care physician regarding the assessment outcome and/or disposition.

Health Plan Behavioral Health Network Contact Information

Medi-Cal Managed Care Health Plan	Non-Specialty Behavioral Health Services Provider	Contact Information
Health Net	MHN	Fax: (855) 703-3268 Phone: (800) 675-6110 (Follow member prompts)
Health Net – Molina	Molina	Fax: (562) 499-6105 Phone: (888) 665-4621
L.A. Care	Beacon	Fax: (866) 422-3413 Phone: (877) 344-2858
L.A. Care – Anthem	Anthem	Fax: (855) 473-7902 (Attn: Medi-Cal BH) Email: Medi-CalBHUM@wellpoint.com Phone: (888) 831-2246 (Option 1 for BH, 2 for BH Intake)
L.A. Care – Care 1st	Beacon	Fax: (877) 752-3257 Phone: (855) 765-9701
L.A. Care –Kaiser	Kaiser	**See below for Regional Offices:**
Bellflower Area – Downey/Norwalk	Fax: (562) 657-2497 Phone: (562) 807-6200	San Fernando Valley – Woodland Hills Fax: (818) 592-3015 Phone: (855) 701-7955
Lancaster	Fax: (661) 951-2999 Phone: (661) 951-0070	San Gabriel Valley – Baldwin Park/West Covina Fax: (626) 856-3010 Phone: (626) 960-4844
Los Angeles – Sunset	Fax: (323) 783-4299 Phone: (323) 783-2600	South Bay Fax: (310) 517-3499 Phone: (310) 325-6543
Panorama City – Santa Clarita/Reseda	Fax: (818) 758-1336 Phone: (818) 758-1200	West L.A. Fax: (323) 298-3119 Phone: (323) 298-3100
Cal MediConnect Health Plan	**Non-Specialty Behavioral Health Services Provider**	**Contact Information**
Care 1st	Beacon	Fax: (877) 752-3257 Email: cmc_Care1st@beaconhs.com Phone: (855) 765-9701
CareMore	Beacon	Fax: (877) 749-3734 Email: cmc_caremore@beaconhs.com Phone: (855) 371-8092
Health Net	MHN	Fax: (855) 703-3268 Email: MHN.CMC@MHN.COM Phone: (855) 464-3571
L.A. Care	Beacon	Fax: (800) 916-4102 Email: cmc_lacare@beaconhs.com Phone: (877) 344-2858
Molina	Molina	Fax: (562) 499-6105 Phone: (855) 665-4627