



Partnership HealthPlan Behavioral Health Referral Form

Email: BH-Access@partnershiphp.org or Fax: (707) 914-0453

Member Information:

Referral Date: _____ Member Name: _____ Medi-Cal CIN ID#: _____

Phone: _____ (home) _____ (member's cell) Best day/time to reach the member: _____

Youth/ Adolescent Services:

Member is under the age of 18 Yes No

Parent/Guardian Name: _____

Parent/guardian's phone number: _____ Best day/ time to reach the parent/guardian: _____

Does the minor (12 and older) have capacity to give consent to services? Yes No

Youth's phone number: _____ Best day/ time to reach the youth: _____

Referring Provider:

PCP Clinic/Agency: _____ Name of PCP: _____ PCP Phone #: _____

To receive confirmation of this referral's outcome, please check the box below noting preferred method & contact details:

Email address: _____ Fax Number: _____

PCP Request

Reason for referral: (select the appropriate referral reason(s) below)

- Mental Health Services
- Substance Use Disorder Services
- Medication for Addiction Treatment
- Eating Disorder Services
- Neurological Testing
- Maternal Mental Health
- Other, please specify: _____

Symptoms: (check all that apply):

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Perinatal depression/anxiety | <input type="checkbox"/> PTSD/Trauma |
| <input type="checkbox"/> Poor self-care due to mental health | <input type="checkbox"/> Violence/Aggressive behavior | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusions) | <input type="checkbox"/> Psychological testing | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Adverse Childhood experiences (ACEs) | <input type="checkbox"/> Neuropsychological testing | |
| <input type="checkbox"/> Substance use, please specify: _____ | | |
| <input type="checkbox"/> Other BH symptoms: _____ | | |

Impairments:

- Difficulties/Unable to complete ADLs
- Difficulties maintaining relationships
- Legal
- CPS
- Difficulties/Unable to go to work/school
- Other: _____

Submission of this form confirms member is aware of this referral.

For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.