Carelon Behavioral Health/Blue Shield of California Promise Health Plan Primary Care Physician Referral Form

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

Referring Provider: _____Name of Clinic/Agency:_____

Member Name:_____ Medi-Cal CIN #:_____ DOB: _____

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

Best day/times to reach member:_____ _____(cell) ☐ **Please check** to confirm member eligibility was verified

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 Carelon 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:* ***877.321.1787*** *OR secure email: PCPReferrals@carelon.com*

☐ **Outpatient Behavioral Health Services:** Refer members interested in therapy or medication management via Carelon's network when needs are outside PCP scope. Carelon coordinates with county mental health. *Fax form to:* ***877.321.1787*** *OR secure email: PCPReferrals@carelon.com*

Request Reason (check all that apply): *Symptoms:*

☐Depression	☐ Perinatal depression/anxiety	☐ PTSD/Trauma
☐Poor self-care due to mental health	☐ Abuse/CPS	☐ Violence/Aggressive bx
☐Psychosis (auditory/visual hallucinations, delusional)	☐ Psychological testing	☐ Chronic Pain
	☐ Neuropsychological testing	☐ Anxiety
☐ Adverse Childhood experiences (ACEs)		

☐Substance use type: _____

☐Other BH symptoms: _____

Impairments:

☐Difficult/Unable to complete ADLs ☐Difficulties maintaining relationships ☐Legal/CPS

☐Difficult/Unable to go to work/school ☐Other:_____

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

_____

Motivation for Services (check all that apply)

☐ Member (or guardian) has been informed or referral to Carelon Behavioral Health

☐ Member wants services for self (or dependent)

☐ If applicable, Patient has completed a PHQ-2/PHQ-9, Score _____