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 Addition Treatment
☐ Eating Disorder Services
☐ Neurological Testing
☐ Maternal Mental Health
☐ Other, please specify: ____

Symptoms: (check all that apply):

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

Impairments:

☐Difficulties/Unable to complete ADLs
☐Difficulties/Unable to go to work/school
☐Difficulties maintaining relationships
☐Other:__________________________________
☐ Legal ☐ CPS

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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.