L.A. Care HEALTH PLAN®

Behavioral Health Support Referral for Minors

If you would like to refer your patient for Behavioral Health Services (including ABA/BHT, mental health or substance use services), please submit the completed referral form **via e-mail** to L.A. Care's Behavioral Health Department behavioralhealth@lacare.org**.** Our services coordinator will contact the member to initiate the process. If the PCP would like to discuss the referral, please call **(844) 858-9940**.

Patient Information

Patient's Name: ______________________________ Date of Birth: ____________ Medi-Cal ID#: _________________

Address:_______________________________________ City, State, Zip code: _________________________________

Preferred Language: ________________________ Diagnosis: ____

Primary Phone Number: _____________________ Secondary Phone Number: ____________________________

Caregiver's Name (if applicable): _________________________ Is minor/caregiver aware of the referral? ☐ Yes ☐ No

Is the minor in crisis? ☐ Yes ☐ No **If yes, please direct the minor to the nearest emergency room or call 911.*

Has the minor ever been in a psychiatric hospital? ☐ Yes ☐ No If known, last date of admission: ________________

Was the ACEs questionnaire completed? ☐ Yes ☐ No If yes, score __________

Please select reason for referral (select all that apply):

☐ ABA/BHT Services ☐ Mental Health Services ☐ Substance Use Services
☐ Occupational therapy ☐ Physical therapy ☐ Speech therapy
☐ Other services (please specify): ____

Brief description for referral reason: ____

Additional Resource for Providers

PCP Decision Support: To schedule a mental health educational conversation with a Carelon Behavioral Health psychiatrist related to psychiatric diagnoses/medications, please contact the National Peer Advisor line during business hours (Monday through Friday 6:00am-5:00pm PST) at **(877) 241-5575.**

Referring Party Information

Provider Name: ____ Referral Date: ___________________

Clinic/Hospital Name: _____________________________________ Date of office visit: _______________

Address: ____ City, State, Zip code: __________________________

Phone number: ____________________ Fax: ____________________ E-mail: ______________________________

Provider Signature: ____________________________ License Number: _______________________

THIS FORM DOES NOT SERVE AS AN AUTHORIZATION REQUEST FORM.

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