Transition of Care Request Form

CenCal HEALTH
Local. Quality. Healthcare.

Please fax completed Transition of Care form and the Level of Care Screening form to the Behavioral Health Department at (805) 681-3070 or upload at https://gateway.cencalhealth.org/form/bh.
Questions? Please call (805) 562-1600.

This form is used to refer members to the County Department of Behavioral Health.

REFERRING PROVIDER (Choose One)

County Mental Health Provider:

- ☐ Santa Barbara County Mental Health Plan
- ☐ San Luis Obispo County Mental health Plan

CenCal Health:

- ☐ CenCal Health Behavioral Health Department
- ☐ CenCal Health Behavioral Health Provider (Contracted Provider or FQHC Provider)

Submitting Agency:

Submitting Program/Clinic:

Contact Name:

Title/Discipline:

Email Address:

Address:

City: State: Zip:

Phone:

CLIENT INFORMATION

Client Name: Date of Birth (MM/DD/YYYY):

☐ Client in Agreement with Transition of Care (Required)

Gender Identity: ☐ Male ☐ Female ☐ Other:

Phone: Address:

City: State: Zip:

Caregiver/Guardian (if applicable):

CenCal Health Member ID (required):

Medi-Cal CIN# (if known):

CLIENT INFORMATION (cont.)

Behavioral Health Diagnosis:

Current Medications/Dosage:

Medication	Dosage	Administration	Date started

Current symptoms and brief treatment history:

A description of what needs are not being met at the current level of care:

Services Requested:

- ☐ **Psychotherapy**
- ☐ **SUD Services** (Must include a signed ROI from Member to exchange information with the "Santa Barbara County Department of Behavioral Wellness" or "County of San Luis Obispo Behavioral Health Department.)
- ☐ **Medication Management** (psychiatry)
- ☐ **Other:**

SCREENING OUTCOME

☐ Total Score: 0-3 = Mild	CenCal Health/Managed Care Plan
☐ Total Score: 4-6 = Moderate	CenCal Health/Managed Care Plan
☐ Total Score: 7-9 = Severe	County/Managed Health Plan