Molina Healthcare of California
Coordination of Care Form
Phone Number: (888) 562-5442 ext 127604
Fax Number: (562) 499-6105

Member Information

Referring Party/County:_____ Date of Evaluation:_____

Member Name:_____ DOB:_____

Member ID:_____ MediCal ID#:_____

Member Address:_____ Member Phone:_____

County:_____ Language:_____

Interpreter Used: ☐

Additional Information

Primary Guardian Information (Name & Phone):_____

Living Arrangements: ☐ Private Home ☐ Board & Care ☐ Relative Placement ☐ Homeless ☐ Other

Physical Limitations: ☐ Hearing Impaired ☐ Visually Impaired ☐ Wheelchair Dependent

Member Signed Release of Information: ☐ Yes ☐ No (If No, this information will NOT be forwarded to the PCP)

Confidentiality Statement Read to Member: ☐ Yes ☐ No

Treatment History

Primary Care Physician:_____ Primary Care Physician Phone #: _____

Current BH provider	*Provider Name*	*Telephone Number*	*Agency*	*Last Appt.*
Therapist/Program				
Psychiatrist				
Other				

Referral/Service Type Requested

Service is For:

☐ Physical Health ☐ Substance Abuse ☐ Mental Health – County Referral

☐ Mental Health – Managed Care (check as many as applicable)

☐ Medication Evaluation/Consult ☐ Medication Management ☐ Individual / Group Therapy

☐ Neuropsychological /Psychological Testing

Presenting/Current Symptoms Rating of Level of Severity: *1 = Mild; 2 = Moderate; 3 = Severe; or N/A*

High Risk Factors: *(For symptoms rated 2 or 3, please provide specific information under the Additional Information section)*

	1	2	3	n/a
Suicidal Ideation	☐	☐	☐	☐
Suicide Plan	☐	☐	☐	☐
History of Suicide Attempt(s)	☐	☐	☐	☐
Homicidal Ideation	☐	☐	☐	☐
Homicide Plan	☐	☐	☐	☐
History of Homicide Attempt(s)	☐	☐	☐	☐
Gravely Disabled	☐	☐	☐	☐
Self-Injurious Behaviors	☐	☐	☐	☐
Child Runaway	☐	☐	☐	☐

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History of Psychiatric Hospitalization:

☐ None ☐ Within last 30 days ☐ Within last 3 months

Intervention Provided, if applicable: (check boxes):

☐ Crisis Intervention ☐ Crisis Response Team ☐ Emergency Responder

Medications, if known

Medication	Dosage	Days Supplied	Date filled	Compliant?	At risk of running out/ out of meds?

Additional Factors:

	1	2	3	n/a
Anxiety	☐	☐	☐	☐
Sleep Disturbances	☐	☐	☐	☐
Appetite Issues	☐	☐	☐	☐
Significant Weight Gain/Loss	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐
Mood Lability	☐	☐	☐	☐
Cognitive Deficits	☐	☐	☐	☐
Somatic Complaints	☐	☐	☐	☐
Anger Outbursts	☐	☐	☐	☐
Aggressiveness	☐	☐	☐	☐

	1	2	3	n/a
Attention Issues	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Dizziness/Light Headed	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐
Confusion	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Dementia	☐	☐	☐	☐
Isolative	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐

Member Provider Choice:_____

Additional Information (explanation of any checked symptoms or other information: