

CenCal Health

Eating Disorder Collaboration Request



MEMBER INFORMATION

Member Name: CenCal ID:

Address: City:

State: Zip: Phone: Date of Birth:

Physical Health Provider (essential):

CenCal Behavioral Health Provider: Yes No

If Yes, Name:

CenCal Health Case Manager:

Contact Information:

Level of Care/Placement being sought:

Contact Person (if different):

COUNTY TO ENTER

County Contact Information:

Is Referral from a County Mental Health Plan? Yes No

County:

Fiscal Contact (name, phone, email):

County Behavioral Health Provider: Yes No

If Yes, Name and Contact Information:

CLINICIAN WITH PRINCIPAL RESPONSIBILITY FOR EATING DISORDER DIAGNOSIS/REFERRAL

Name and Licensure of Principal Provider:

Type of Licensure: Phone/email:

Agency: Clinic:

CLIENT HEALTH INFORMATION

Current BMI:

Co-occurring Conditions (medical, psychiatric, substance use):

Current Location of Client (i.e., home, facility, foster care, etc.):

Current Services to Address Client's Eating Disorder:

Level of Care/Placement being sought:

Anticipated length of stay:

Summary Information:

Please provide details on how the client was first diagnosed with an eating disorder or first came to your attention, and how the proposed level of care was determined including interventions/treatment/provided to date:

CLIENT HEALTH INFORMATION (cont.)

Discharge Planning:

[Redacted area for Discharge Planning]

Who will be Monitoring the Client's Care During the Placement?

[Redacted area for monitoring person]

Anticipated Steps upon Discharge? Is there a need for case management support to ensure access to medically necessary care, services, or providers?

[Redacted area for anticipated steps upon discharge]

Consent/Responsible Party (if not the client):

[Redacted area for consent/responsible party]

Please note that collaboration involves communication about the client's progress on at least a monthly basis during the period of collaboration.

Please fax this form to the Behavioral Health Department (805) 681-3070 or upload to <https://gateway.cencalhealth.org/form/bh>.

Questions? Please call (805) 562-1600