MH 718
Revised 4/19/19

SERVICE REQUEST LOG

Provider Number (5 digit program code): _____

I. Request Information

Date of Request: _____ Time of Request: _____ Recording Staff: _____

Reason for Request: _____ Request Type: ☐ *Call* ☐ *Walk-In* ☐ *Other* ☐ *SRTS*

Is this an urgent request? ☐ *Yes* ☐ *No* SRTS Reference Number: _____

Situation will likely result in an immediate emergency psychiatric condition if not addressed within 48 hours

II. Requester/Referring Party **Client includes a potential client*

Last Name: _____ First Name: _____ Contact Number: _____

Referring Party Role:
☐ *Self* ☐ *Collateral/Family Member* ☐ *ACCESS* ☐ *Other*
☐ *DCFS* ☐ *Health Provider* ☐ *Inpatient Facility* ☐ *School*
☐ *Probation/Law Enforcement* ☐ *APS* ☐ *Mental Health Provider* ☐ *DPSS*

Referring Facility/Site/School: _____ Type of Role: _____

Is the client*/legal representative aware of the referral? ☐ *Yes* ☐ *No*

III. Client/Potential Client Information

Existing Client: ☐ *Yes* ☐ *No* Client ID: _____

Potential Client Last Name: _____ Potential Client First Name: _____

Potential Client Contact Number: _____ Potential Client DOB: _____

Insurance Status: ☐ *Indigent* ☐ *Medi-Cal* ☐ *Medicare* ☐ *Medi-Medi* ☐ *Private Insurance* ☐ *Unknown*

Preferred Language: _____

If Minor's Legal Guardian is not the referring party: Legal Guardian Name: _____

Contact Number: _____ Date client*/legal representative agreed to services:_____

IV. Clinical Information

Currently Receiving Outpatient Mental Health Services: ☐ *Yes* ☐ *No* ☐ *Undetermined* If yes, where/from whom? _____

Been on psychotropic medications w/in the past 30 days? ☐ *Yes* ☐ *No* ☐ *Unknown*

Release From (in the past 7 days): ☐ *Inpatient* ☐ *Juvenile Hall* ☐ *Jail* ☐ *N/A* Actual/Expected Discharge/Release Date: _____

If release from inpatient facility, name of facility: _____

V. Disposition

☐ *Crisis Referral (this site, 911, FRO)* ☐ *Assessment Appointment Given this Site* ☐ *Referred to System Navigation*
☐ *Referred back to Private Insurance* ☐ *Referred to Another MH Provider* ☐ *Referred to Other Type Agency*
☐ *Other* ☐ *Individual/Collateral Declined Services* ☐ *Unable to Contact Individual/Collateral*
☐ *Already Receiving Appropriate MH Services* ☐ *Untimely Appointment This Site, Referral Declined*

If appointment given:
Appointment Practitioner: _____ Appointment Program: _____
Appointment Date: _____ Appointment Time: _____
Was an earlier appointment offered: ☐ Yes ☐ No If yes, date of first offered appointment: _____

If medication appears to be a need:
☐ *Medication Appointment Given this Site* ☐ *Interim Referral for Medication Evaluation*
☐ *Medication Needs TBD at Initial Assessment* ☐ *Other*
Med Appointment Practitioner:_____ Medication Appointment Program: _____
Medication Appointment Date: _____ Appointment Time: _____
Was an earlier appointment offered: ☐ Yes ☐ No If yes, date of first offered appointment: _____

Disposition Details:

Comments, Cultural Considerations and/or Special Needs:

IV. ACCESS STAFF ONLY

ACCESS Appointment Line: ☐ *Yes* ☐ *No* Source: ☐ *Managed Care Referral* ☐ *DHS eConsult* Priority/Routine: ☐ *Priority* ☐ *Routine*

Referring Health Plan:
☐ *LA Care* ☐ *Health Net* ☐ *Beacon Behavioral Health* ☐ *MHN Behavioral Health* ☐ *Kaiser*
☐ *Anthem* ☐ *Care 1st* ☐ *Molina* ☐ *Other* ☐ *Indigent*

Staff Signature*	**Date**	**Co-Signature***	**Date**

SERVICE REQUEST LOG (SRL)