MH 718
Revised 2/5/21

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*

Is this an urgent request? ☐ *Yes* ☐ *No* (*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* ☐ *Initiated Outreach & Engagement*

If appointment given:	Appointment Practitioner: _____	Appointment Program: _____
	Appointment Date: _____	Appointment Time: _____
	Was an earlier appointment offered: ☐ Yes ☐ No	If yes, date of 1st offered appointment: _____
	If yes, date of 2nd offered appointment: _____	If yes, date of 3rd offered appointment: _____
If medication appears to be a need:	☐ *Medication Appointment Given this Site* ☐ *Medication Needs TBD at Initial Assessment*	☐ *Interim Referral for Medication Evaluation* ☐ *Other*
	Med Appointment Practitioner:_____	Medication Appointment Program: _____
	Medication Appointment Date: _____	Appointment Time: _____
	Was an earlier appointment offered: ☐ Yes ☐ No	If yes, date of 1st offered appointment: _____
	If yes, date of 2nd offered appointment: _____	If yes, date of 3rd 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**

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

SERVICE REQUEST LOG (SRL)