

PROVIDER COMMUNICATION

TYPE OF COMMUNICATION REQUESTED: CONSULTATION

SENDER*

RECIPIENT*

Agency: _____
Address: _____
Contact Person: _____
Phone Number: _____ Fax Number: _____
E-mail: _____

Agency: _____
Contact Person: _____
Phone Number: _____
Fax Number: _____
E-mail: _____

PRACTITIONER INFORMATION*

Name: _____ Title: _____
Contact Information (if different from Sender information above): _____
Provider Signature: _____ Date: _____

CLIENT INFORMATION*

Name: _____ Medi-Cal CIN: _____ DOB: _____
Address: _____ Phone Number: _____
Gender: _____ Preferred Language: _____ Ethnicity: _____
Caregiver's Name (if applicable): _____ Preferred Language: _____ Phone Number: _____
Payor Source: Medi-Cal Only Medicare Only Medi-Medi Uninsured Other _____

DOCUMENTS PROVIDED – or – REQUESTED*

Note: The release of Protected Health Information may require a signed client authorization under certain circumstances.

Check as many boxes as applicable: Authorization History & Physical Laboratory (specify) _____
 Assessment Assessment Summary Treatment Plan Treatment Summary Problem List Medication List
 Progress Notes Consultation Outcome Discharge Plan Other (specify) _____ None
Explanation/Additional Comments: _____

Request for Forensic Consultation - Required Information *(The client/practitioner must be available on Mondays for consultation)*

AOT Evaluation Violence/Risk/Threat Assessment Suicide Risk Assessment LPS Conservatorship
 Juvenile Court Mental Health Services Consult Tarasoff Reporting Child/Elder Abuse Reporting Confidentiality Questions
 Ethical Questions Other

Description of question or request: _____

Signature of Program Manager or Supervising Psychiatrist: _____ Date: _____

Signature of District Chief: _____ 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.

DMH USE ONLY
Name: _____ DMH ID#: _____
Agency: _____ Provider #: _____
Los Angeles County – Department of Mental Health

What is a Forensic Psychiatry Consultation?

The purpose of the Forensic Psychiatry Consultation service is to provide forensic mental health consultation to DMH directly-operated clinics around a variety of issues. These may include:

- Assisted outpatient treatment (AOT) evaluation
- Violence risk assessment/threat assessment
- Suicide risk assessment
- LPS conservatorship (contested or challenging)
- Juvenile Court Mental Health Services consult (these also would come directly via JCMHS)
- "Tarasoff" reporting questions
- Child or elder abuse reporting questions
- Confidentiality questions
- Ethical questions
- Other (involving interface of psychiatry/mental health and the law)

Consultations can involve direct evaluation of clients, record review, and/or discussion of issues related to legal or ethical questions around mental health and the law. Initial consultations will be performed by UCLA Forensic Psychiatric Fellows, who will be supervised by UCLA Forensic Psychiatry Faculty members and/or DMH Supervising Mental Health Psychiatrists/Mental Health Psychiatrist with a current Forensic Psychiatry Certification by the American Board of Psychiatry and Neurology.

Instructions on how to request a Forensic Psychiatry Consultation:

1. Complete the Provider Communication Form MH707FC (Forensic Consult version)
2. Obtain District Chief's signature/authorization. District Chief will submit request via email to ForensicConsultation@dmh.lacounty.gov. The consultation request will be forwarded to the appropriate DMH Forensic Psychiatry Division Supervisors and the UCLA Forensic Psychiatry Fellowship Director.
3. UCLA Forensic Psychiatry Fellowship Director, UCLA Forensic Psychiatry Faculty, and/or appropriately qualified DMH Supervising Mental Health Psychiatrist/Mental Health Psychiatrist will review the request to determine its appropriateness and the Fellowship Program's capacity to complete the consult in a timely manner.
4. If accepted, the consultation request will be forwarded to the UCLA Forensic Psychiatry Fellow, who will contact the requesting individual/program to schedule the evaluation (if necessary) or meeting time. Most evaluations or meetings will take place on Mondays, though there may be more flexibility for record review and phone consultations.
5. After reviewing records, collateral information, and/or conducting the evaluation, the UCLA Forensic Psychiatry Fellow will discuss the consultation with his/her supervisor.
6. The UCLA Forensic Psychiatry Fellow will provide both verbal and written recommendations and additional feedback to the requestor. Written recommendations can be scanned into IBHIS.

Please note that because of the limited resources available to this program (two UCLA Forensic Psychiatry Fellows working 8-10 hours/week), not all consultations will be accepted. If the requestor is not contacted, they should assume that a consultation will not be performed.

Also, this service will not address emergent or urgent forensic mental health issues, and in no way replaces other assessments/actions/interventions urgently (e.g., violence risk assessment, acute suicide risk assessment) that may be appropriate and needed when these emergent or urgent situations arise.