SAN MATEO COUNTY
MENTAL HEALTH SERVICES DIVISION

REQUEST FOR SELF/TEAM REFERAL

Client Name _____ **MH #** _____

Clinician Name _____ **Therapist #** _____

Clinical justification to support request: (Include chart if available.)

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Circle one

_____
Clinician's Signature Date

Approved Deferred Denied _____
Supervisor's Signature Date

Approved Deferred Denied _____
Clinical Manager's Signature Date

Approved Deferred Denied _____
Director of Mental Health Services Date