



Policy 93-12 Attachment A: Request for Self/Team Referral

Client Name _____ **MH #** _____

Clinician Name _____ **Therapist #** _____

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

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