San Mateo County Mental Health Services
REQUEST for REFERRAL to UNIQUE CLINICAL SERVICE

Client _____ MH# _____

Therapist/Coordinator _____ Program _____

Treatment Need _____

Referral/Service Requested _____

_____

Brief description of prior efforts to meet this need with existing resources, or inpatient/ outpatient intake information; progress notes or record of team/clinical conference may be attached_____

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Client's involvement in proposed unique treatment _____

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_____ Approval of Unit Chief (and team if appropriate)

_____ ACCESS Team consulted

Requesting Clinician _____ Date _____

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_____ Initialed by Adult or Youth Services Manager – approves of treatment request and will coordinate efforts to obtain the unique, medically necessary, service.

If denied by clinical services manager, request may be appealed.

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_____ Initialed by Assistant Director of Mental Health Services – approves vendor agreement or contract with unique treatment provider as requested.