



Policy 99-07 Attachment A: 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

Client's involvement in proposed unique treatment _____

_____ Approval of Unit Chief (and team if appropriate)

_____ ACCESS Team consulted

Requesting Clinician _____ Date _____

_____ 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.

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