Alameda County Behavioral Health Care Services

REQUEST FOR PRIOR CONSULTATION

USE TO OBTAIN AUTHORIZATION/APPROVAL BEFORE CLIENT HAS BEEN SEEN. SUBMIT THIS INFORMATION DIRECTLY TO ACCESS PROGRAM ALONG WITH BENEFICIARY REGISTRATION FOR PRIOR CONSULTATION FORM AND SCREENING FORM FOR APPROPRIATE AGE..

BENEFICIARY NAME: _____

BIRTH DATE: _____

SSN: _____

MEDI-CAL NUMBER: _____

Referral Source/Agencies Involved in Referral

_____

Presenting Problem

_____

_____

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Functional Impairments

_____

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_____

CLINICIAN NAME: _____

PHONE: _____ EXT. _____ FAX: _____

IF ORGANIZATION, GIVE NAME: _____

SIGNATURE: _____ LICENSE: _____ DATE: _____