Riverside University HEALTH SYSTEM Behavioral Health

Attachment **N**

Reply to: Behavioral Health
Quality Improvement Outpatient
2085 Rustin Avenue, Suite 2002
Riverside, CA 92507

This fax cover sheet must be completed and used when submitting a Medication Declaration.

Date: _____

To: Quality Improvement Outpatient
Fax # (951) 955-7203

From: _____

Address: _____

Phone #: _____

Fax #: _____

Client Name: _____

Social Security # of Client: _____

Client ELMR ID #: _____

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PROPOSED TREATMENT AND FOLLOW UP SERVICES

Referral Source: ☐ ACT ☐ CARES ☐ TRAC

Psychiatric Evaluation:

____ session(s) per ☐ week / ☐ month for____ ☐ weeks / ☐ months (☐ 15, ☐ 30, ☐ 60 mins.)

Collateral Visit:

____ session(s) per ☐ week / ☐ month for____ ☐ weeks / ☐ months (☐ 30, ☐ 60 mins.)

Collateral Sessions with: _____