

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: \_\_\_\_\_

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