



DEPARTMENT OF BEHAVIORAL HEALTH

Please print or type

OUTPATIENT TREATMENT AUTHORIZATION REQUEST FOR ADULTS

Every item must be completed. Please FAX to (909) 890-0353.

Client Name: _____ DOB: _____
SSN: _____ Financial/Insurance Status: _____
Address _____ City & Zip Code _____
Telephone Number _____ SIMON # _____
Clinic _____ Primary Clinician _____
Primary Clinician Telephone Number _____

Table with 3 columns: Type of Service, Frequency, Beginning Date. Title: Current Client Services

Table with 4 columns: Type of Service, Frequency, Length of Service Period, Number of Visits Requested. Title: Services For Which Authorization Is Being Requested

Please check one: Service need is [] Urgent [] Not Urgent

Please describe your treatment goals and termination criteria (Termination criteria should be behaviorally specific, quantified, and time limited)

Horizontal lines for describing treatment goals and termination criteria

Current Problem

Horizontal lines for describing current problem



SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

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Outpatient Treatment Authorization Request--Adults

Client Name _____

Current Medications			
Medication	Dosage	Frequency	Target Symptoms

Prior Hospitalization(s) Yes No If "Yes," when/where?

Other Providers/Agencies Providing Services to Client: _____

Please describe your rationale for the authorization request you are making: _____

Why would a different service activity not be appropriate for this client? (For example, if you are requesting authorization for day treatment services, please explain why group therapy and referral to a clubhouse would not constitute an appropriate set of alternatives.)

Please describe any previous experiences this client has had with the service activity for which you are requesting authorization. Describe the dates, lengths of treatment, and the outcomes.



**SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH**

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Outpatient Treatment Authorization Request--Adults

Client Name _____

DSM-IV DIAGNOSES		
	DSM-IV Code	Diagnosis/Description
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V	GAF Score =	

Clinic Supervisor Signature _____

Date _____

SERVICES APPROVED		
Type of Service	Authorization Expires On	Number of Visits Approved

SERVICES NOT APPROVED		
Type of Service	NOA Issued	Date NOA Issued

REFERRALS PROVIDED

Access Unit Staff (Printed) _____

Access Unit Staff Signature _____

Date _____

[If you have any questions regarding the actions taken by the Access Unit, please telephone (909) 386-8256 and ask to speak with the clinician whose name appears above.]