



**SAN BERNARDINO COUNTY  
DEPARTMENT OF BEHAVIORAL HEALTH**

Please print or type

**OUTPATIENT TREATMENT AUTHORIZATION REQUEST  
FOR CHILDREN/ADOLESCENTS**

*Every item must be completed. Please FAX to (909) 386-0775.*

Client Name: _____		DOB: _____
SSN: _____	Financial/Insurance Status: _____	
Address _____		City & Zip Code _____
Telephone Number _____	SIMON # _____	
Name of Parent/Legal Guardian _____		
Primary Residence <input type="checkbox"/> Family <input type="checkbox"/> Foster Home <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____		
Clinic _____		Primary Clinician _____
Primary Clinician Telephone Number _____		

Current Client Services		
Type of Service	Frequency	Beginning Date

Services For Which Authorization Is Being Requested			
Type of Service	Frequency	Length of Service Period	Number of Visits 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)**

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**Current Problem**

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Outpatient Treatment Authorization Request--Children/Adolescents

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.)

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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.

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Outpatient Treatment Authorization Request--Children/Adolescents

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) 421-9272 and ask to speak with the clinician whose name appears above.]