County Of San Bernardino
Department of Behavioral Health

INITIAL CONTACT LOG
TELEPHONE, WALK-IN AND WRITTEN REQUESTS FOR SERVICES

NAME OF CLINIC_____ **REPORTING MONTH/YEAR_____**

TITLE 9 REQUIRES THAT ALL INITIAL REQUESTS FOR SERVICES MUST BE LOGGED

	DATE AND TIME	** URGENT YES√ NO√	NAME OF CALLER AND RELATIONSHIP TO BENEFICIARY (Last Name, First Name)	NAME OF BENEFICIARY (Last Name, First Name)	INTERPRETER SERVICES OFFERED YES√ NO√ (LANGUAGE)	*** CALLER'S RESPONSE TO OFFER OF INTERPRETER SERVICES	REASON FOR CALL	INITIAL DISPOSITION	**RESPONSE TIME TO OBTAIN URGENT SERVICES	STAFF NAME
1		☐ ☐			☐ ☐					
2		☐ ☐			☐ ☐					
3		☐ ☐			☐ ☐					
4		☐ ☐			☐ ☐					
5		☐ ☐			☐ ☐					
6		☐ ☐			☐ ☐					
7		☐ ☐			☐ ☐					

MHP REQUIRES A MAXIMUM RESPONSE TIME OF 2 HOURS FOR ALL REQUESTS FOR URGENT SERVICES. * ENTER 1) ACCEPTED OR 2) REFUSED