County of San Bernardino
Department of Behavioral Health

Physician Request Form

Client Name _____

Simon Number _____

Date Requested: _____

Office Assistant Name: _____

Doctor _____,

The following check off items need your attention. If the item requires a form it is attached. Please complete the form as indicated and/or obtain client signature. Please leave the form and this notice with the chart for pickup. Thank You

- ☐ Client Plan Expires _____
- ☐ Client Plan Expired – Please complete a new one
- ☐ Client Plan Incomplete – Please complete checked sections
  - ☐ Planned Services (check MSS box)
  - ☐ Measurable Objectives (please write)
  - ☐ Dysfunction Rating (check box)
  - ☐ Behavioral Evidence for Dysfunction Rating (written)
  - ☐ MSS Modality Frequency (how often will you see the client)
  - ☐ MSS Planned End Date (match to the day preceding episode opening date, using the next year, D.O.E. is on label on chart)
  - ☐ MD Date, Signature, Printed Name, MSS Modality
  - ☐ Client Date, Signature (required on every plan since 12/04/06)
  - ☐ Plan start date, Plan end date (cannot exceed one year)
- ☐ Psychiatric Evaluation
- ☐ AIMS
- ☐ Physical Assessment
- ☐ Other _____