*Open Door Community Health Center*

# Behavioral Health Patient Request for Case Review

Patient: _____

Medical Record Number: _____

Date: _____

Behavioral Healthcare Provider: _____

Recommendation: _____

_____

_____

_____

Patient's Concerns: _____

_____

_____

_____

_____

1. Patient's PCP has been notified: Yes ____ No ____
2. Patient has been advised of right to case review: Yes ____ No ____
3. Patient has requested a case review: Yes ____ No ____
4. Medical Director notified of request for review: Yes ____ No ____
5. Case review conducted: Yes ____ No ____
6. Review committee members: _____ _____

   _____
7. Review committee decision: _____

   _____

   _____
8. Patient has been notified of the committee's decision: Yes ____ No ____

Signature: _____

Date:_____