



**SUBSTANCE ABUSE PREVENTION AND CONTROL
PHYSICIAN CONSULTATION REQUEST FROM**

Mail: Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803
To check submission status call: (XXX) XXX-XXXX

Website: <http://publichealth.lacounty.gov/sapc/>
Fax: (XXX) XXX-XXXX

PATIENT INFORMATION

1. Name (Last, First, and Middle)	2. Date of Birth (MM/DD/YY):	3. Today's Date:
4. Medi-Cal Identification Number:	5. Gender:	6. Race/Ethnicity:
7. Perinatal Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Criminal Justice Involved Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	

PROVIDER AGENCY INFORMATION

9. Agency Name:	
10. Name of the Referring Physician:	11. Phone Number of Referring Physician:
12. Email Address:	13. Fax Number:

CLINICAL INFORMATION

14. Diagnosis(es):	15. Current ASAM Level of Care:
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REASON FOR CONSULTATION AND RELEVANT CLINICAL DETAILS

16.

TREATMENT INTERVENTIONS PROVIDED

17.

RECOMMENDATIONS (To be completed by Consulting Physician)

18.

CONSULTING PHYSICIAN INFORMATION

19. Print Consulting Physician Name:	20. Consulting Physician Signature:	21. Date:
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DISCLAIMER

These recommendations/suggestions are based on conversations(s) with the Referring Physician. The consultant has not personally examined the patient. Given the indirect nature of this consultation, recommendations should be implemented with consideration of the unique aspects of the patient's case (e.g., health history, current clinical status, psychosocial considerations, risk factors, and prognosis). Please contact the SAPC at (626) 299- XXXX if there are additional questions about the care of this patient.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Client Name:	Medi-Cal ID:
Treatment Agency:	

PHYSICIAN CONSULTATION REQUEST FORM INSTRUCTIONS

Physician Consultations are strictly limited to routine consultation requests and for physicians practicing within the network of SAPC providers. The consultations are non-urgent in nature. Emergent and urgent consultation needs should not be requested via the Physician Consultation Service. These requests shall not be initiated by non-physicians or patients.

PATIENT INFORMATION

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter today's date.
4. Enter the patient's Medi-Cal identification number.
5. Enter the patient's gender.
6. Enter the patient's race/ethnicity.
7. Check box if the patient is a perinatal patient.
8. Check box if the patient is a criminal justice patient

PROVIDER AGENCY INFORMATION

9. Enter the name of the agency.
10. Enter the name of the referring physician.
11. Enter the phone number of the referring physician.
12. Enter the email address of the referring physician.
13. Enter the Fax number of the agency.

CLINICAL INFORMATION

14. Enter the patient's diagnosis(es).
15. Enter the current ASAM level of care.

REASON FOR CONSULTATION AND RELEVANT CLINICAL DETAILS

16. Enter the reason for the consultation and relevant clinical details.

TREATMENT INTERVENTIONS PROVIDED

17. Enter the treatment interventions provided.

RECOMMENDATIONS (to be completed by consulting physician)

18. Consulting physician to enter his/her recommendations.

CONSULTING PHYSICIAN INFORMATION

19. Consulting physician to enter his/her printed name.
20. Consulting physician to enter his/her signature.
21. Consulting physician to enter the date.

INTERNAL SAPC USE ONLY

This section reserved for internal SAPC use only.

SUBMIT THE CONSULTATION REQUEST FORM TO:

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