COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
PHYSICIAN CONSULTATION REQUEST FROM

Mail: Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhamabra, 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: ☐ Yes ☐ No	**8. Criminal Justice Involved Patient:** ☐ Yes ☐ 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:**

REASON FOR CONSULTATION, AND RELEVANT HISTORY AND CLINICAL DETAILS

16.

TREATMENT INTERVENTIONS PROVIDED

17.

RECOMMENDATIONS (To be completed by Consulting Physician)

18.

CONSULTING PHYSICIAN INFORMATION		
19. Consulting Physician Name:	**20. Consulting Physician Signature:**	**21. Date:**

DISCLAIMER

These recommendations/suggestions are based on conversation(s) with the Referring Physician and information provided during correspondence. The Consulting Physician has not personally examined the patient and the Referring Physician holds primary responsibility for patient care decisions. Given the indirect nature of this consultation, recommendations should be implemented by the Referring Physician with consideration of the unique aspects of the patient's case (e.g., physical and mental health history, current clinical status, psychosocial considerations, risk factors, and prognosis). Please contact SAPC at (626) 299 -XXXX if there are additional consultation questions about the care of this patient.

Patient 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 be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services). 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 HISTORY CLINICAL DETAILS

16. Enter the reason for the consultation and relevant clinical details that help to inform and provide context for the concern/question.

TREATMENT INTERVENTIONS PROVIDED

17. Enter the treatment interventions provided.

RECOMMENDATIONS (to be completed by consulting physician)

18. Consulting physician to enter his/her recommendations focused on the question/concern of the consultation request.

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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Fax:	(XXX) XXX-XXXX
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