SUBSTANCE ABUSE PREVENTION AND CONTROL
Miscellaneous Note Option

NOTE TYPE			
1. Select note type: ☐ Case Review ☐ Case Management ☐ Miscellaneous Note 2. Start time: _______ ___ _ End time: _ ___ _______ 3. Date:			
PATIENT INFORMATION			
4. Name (Last, First, and Middle):	5. Date of Birth (mm/dd/yyyy):		6. Medi-Cal or MHLA Number:
7. Address:			
8. Gender:	9. Preferred Language:	10. Race/Ethnicity:	11. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
PROVIDER AGENCY			
12. Name:		13. Contact Person:	14. Phone Number:
15. Address:		16. Fax:	17. Email:
NOTE			
18. Please document the activity or encounter:			
19. If the patient preferred language is not English, were linguistically appropriate services provided? Yes No If no, please explain:			
20. Provider Name:		21. Signature:	22. Date:
23. Additional Provider Name if applicable:		24. Signature:	25. Date:

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.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider***.**
Comments: Assigned Staff: __________________ Reviewed by: _______________ Signature: _______________ Date: __________
INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*
Comments: Assigned Staff: __________________ Reviewed by: _______________ Signature: _______________ Date: __________

MISCELLANEOUS NOTE OPTIONS

INSTRUCTIONS: NOTE TYPE:

1. Please select the type of note.
2. Please enter the start and end time of the encounter.
3. Please enter the date of the encounter.

PATIENT INFORMATION

4. Enter the patient name in the order of last name, first name, and middle name.
5. Enter the patient date of birth.
6. Enter the patient Medi-Cal or My Health LA (MHLA) number. If the number is not known, leave the space blank.
7. Enter the patient address.
8. Enter the patient gender
9. Enter the patient preferred language
10. Enter the patient race/ethnicity
11. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.

PROVIDER AGENCY

12. Enter the agency name
13. Enter the contact person
14. Enter the phone number
15. Enter the address
16. Enter the fax
17. Enter the email

NOTE

18. Enter the details of the encounter
19. Enter any linguistically appropriate services if the preferred language is not English
20. Enter the provider name
21. Enter the provider signature
22. Enter the date
23. Enter the additional provider name such as a supervisor, or a second provider present during the encounter.
24. Enter the provider signature
25. Enter the date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

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SUBMIT THIS FORM TO:

Fax: (323) 725-2045
Phone: (626) 299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders.htm