COUNTY OF MONTEREY
HEALTH DEPARTMENT
Nationally Accredited for Providing Quality Health Services

Monterey County Health Department

Behavioral Health Department

Change of Clinician Request Form

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Change of Clinician Request Form

TO: PROGRAM MANAGER OR MEDICAL DIRECTOR

CLIENT NAME: _____
(Please Print)

DATE OF BIRTH: _____

PHONE NUMBER: _____

CURRENT ADDRESS: _____
(Street)

_____
(City) (Zip Code)

TODAY'S DATE: _____

I request a change in my current psychiatrist, psychologist, psychiatric social worker or case manager for the following reason (s):

_____
_____
_____
_____
_____
_____

MY CURRENT CLINICIAN IS_____

CHECK ONE:

_____ I have discussed my concerns with my current clinician.

_____ I have not discussed my concerns with my current clinician.

I understand that a response to this request can be expected in 10 working days.

_ For Staff Use Only _

Actions Taken:_____
_____
_____

Change Request Upheld: ☐Yes ☐No

If Yes, New Clinician:_____

Date Request Reviewed:_____

Date Request Was Resolved:_____

Client MRN #:_____

Program:_____

Reviewer Name (print):_____

Signature:_____

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