MONTEREY COUNTY HEALTH DEPARTMENT
BEHAVIORAL HEALTH DIVISION

CHANGE OF CLINICIAN REQUEST FORM

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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.

Action Taken: _____

_____

_____