24-HOUR NOTIFICATION

Riverside County Department of Mental Health

Quality Improvement Inpatient Authorization and Appeals

Phone: (951) 358-6031

Fax: (951) 358-4474

In case of fax transmission failure, call (951) 358-6031

Hospital Name and City: _____ Hospital Phone #: _____

Patient Name: _____ Male ☐ Female ☐

Marital Status: _____ Ethnicity: _____ DOB: _____ Age: _____

SSN#: _____ Medi-Cal/CIN #: _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Pt Phone #: _____

Responsible Party (if under 18): _____ Relationship: _____

Responsible Party Address: _____

Reason(s) for admission/presenting symptoms **(Must be completed):** _____

_____

_____

_____

Admitting Diagnosis: _____ **Axis I: (Numeric):** _____

Admitting Doctor: _____ **Admit Date and Time:** _____

Medi-Cal: ☐ Indigent (Short Doyle): ☐ Medicare: ☐ Other Healthcare/Self-Pay: ☐ LIHP/RCHC: ☐

Voluntarily: ☐ Involuntary: ☐ / DTS ☐ DTO ☐ GD ☐

Riverside County Conservatee: ☐ / Riverside County Ward of the Court: ☐

Name of Hospital Staff completing form (print): _____

Riverside County Use Only

Date 24 Hour Received: _____ Time Received: _____

Client ID #: _____ ELMR Episode #: _____ RU #: _____

Region: W ☐ D ☐ M ☐ Other ☐ Unknown ☐ Child ☐ Older Adults ☐

Date County Regions Notified: _____

Date Medi-Cal Checked: _____

Mark all that apply: MC ☐ MC-IEHP ☐ MC-Molina ☐ Medi/Medi ☐ LIHP/RCHC ☐

INDIGENT ☐ Unknown ☐ Not Record of Eligibility Found ☐ **OUT OF COUNTY** ☐

Comments: _____

Completed by: _____ Date Entered: _____

CONFIDENTIAL PATIENT INFORMATION: SEE CALIF.W&I CODE 5328