Riverside County Mental Health Plan
Community, Access, Referral, Evaluation, & Support (CARES)

PSYCHIATRIC TREATMENT AUTHORIZATION REQUEST

Date: _____ ☐ Initial TAR ☐ Extension TAR ☐ Change TAR

Provider: _____ Provider #: _____

Provider Phone #: _____ Provider Fax #: _____

Consumer Name: _____

Consumer DOB: _____ Consumer SSN: _____

Consumer Medi-Cal#: _____

Diagnosis: Axis I: _____

_____

Axis II: _____

_____

Axis III: _____

_____

Axis IV: _____

_____

Axis V: _____ / _____
Current Highest in Past Year

Current Medication(s) and Dosage(s):

_____

Prescribed By: _____

Symptoms that impair functioning: _____

_____

Goal(s) of Treatment:

_____

Target Date:

PROPOSED TREATMENT

☐ Psychiatric Evaluation: _____ 15 min session(s) per ☐month ☐quarter for _____ ☐weeks ☐months

Comments

Contractor's Signature and Title: _____ Date: _____

Consumer's Signature: _____ Date: _____

Parent / guardian Signature _____ Date: _____

Community Access, Referral, Evaluation, & Support (CARES)
P O Box 7549 * Riverside, CA 92513 * (951) 358-5352