



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: 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: _____

Client ID #: _____ ELMR Episode #: _____

Region: W D M Other Unknown Child Older Adults

Date County Regions Notified: _____

Comments: _____

Completed by: _____