



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
**CONSULTATION REPORT AND
REQUEST**

DATE

NAME

BIRTH DATE

SEX

MALE

FEMALE

ID NO.

REQUEST FOR CONSULTATION TO (PHYSICIAN OR SERVICE)

REASON FOR REQUEST

BILL:

MEDICAID NO.

MEDICARE NO.

INDIVIDUAL'S FUND

CASEMANAGER

CENTER DIRECTOR

REPORT OF CONSULTATION - DIAGNOSIS, FINDINGS AND RECOMMENDATIONS

REQUEST RECEIVED _____

DATE

CONSULTANT