Lake County Behavioral Health

REQUEST FOR SECOND OPINION

DATE: _____

TO: Treatment Team

FROM: _____
(Client Name)

_____
(Parent or Guardian, if request is by or for child or youth)

I request a SECOND OPINION for the following reasons: _____

_____

_____

_____

_____

_____

_____

My current clinician is: _____

I understand that serious consideration will be given to this request and that I can expect a response. I prefer the following:

RESPONSE TO ME BY TELEPHONE: _____
(Telephone Number)

RESPONSE TO ME BY MAIL: _____
(Street Address)

_____
(City, State, Zip Code)

Information below this line for Office Use only.

❑ Request Approved and New Provider Assigned: _____
❑ Request Denied for the following reason(s): _____

_____

❑ Notification Letter mailed on *(Date)*: _____

Treatment Team Member Signature _____ Date _____

Lake County Behavioral Health **REQUEST FOR SECOND OPINION** *Page 1 of 1*	**Client Name:**
	Client ID #: