Butte County Department of Behavioral Health (BCDBH)
Change of Provider / Second Opinion Request

Print Form

Request for: ☐ **Change of Provider** - or- ☐ **Second Opinion**

☐ **Request has been entered into Avatar. (staff only)**

Client Number:	**Date of Request:**	
Client Name: Last	**First**	**Middle Initial**
Program:	**Episode:**	

Change of Provider:

Reason:

_____

_____

_____

Request for Change in Provider:

☐ **BH Counselor** ☐ **Clinician**
☐ **Facility** ☐ **Mental Health Worker**
☐ **Psych Tech/LVN/RN** ☐ **Psychiatrist/NP**

Type of Problem Resolution:

☐ **Informal** ☐ **Grievance** ☐ **Appeal**

Disposition:

☐ **Granted**
☐ **Request Withdrawn**
☐ **Denied**
☐ **Referred to Patient's Rights**
☐ **Under Review**

New Assigned Provider (Staff Name/ID):

_____

Current Provider (Staff Name/ID):

_____

Second Opinion:

Reason:

_____

_____

_____

Date Offered: _____
(Must be within 10 Days of Request)

Date Accepted: _____

Initial Opinion Given By:

_____

Second Opinion Given By:

_____

Type of Problem Resolution:

☐ **Informal** ☐ **Grievance** ☐ **Appeal**

Disposition:

☐ **Granted**
☐ **Request Withdrawn**
☐ **Denied**
☐ **Referred to Patient's Rights**
☐ **Under Review**

Current Provider (Staff Name/ID):

_____

Name of BCDBH Staff: _____ **Date:** _____

For internal use only- ***Client Name:*** _____
Client ID: