CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

NAME/MRN

CHANGE OF DIAGNOSIS REQUEST FORM

PROGRAM: _____

I. ASSIGNMENT OR CHANGE OF THERAPIST

FROM: _____

TO: _____ Staff # _____

DATE ASSIGNMENT/CHANGE OF THERAPIST TOOK PLACE: _____

II. ASSIGNMENT OR CHANGE OF MD

FROM: _____

TO: _____ Staff # _____

DATE ASSIGNMENT/CHANGE OF MD TOOK PLACE: _____

III. CHANGE OF DIAGNOSIS

DSM 5 Diagnosis: _____(P) ICD-10 Code: _____

Diagnosis Title/Narrative: _____

DSM 5 Diagnosis: _____(S) ICD-10 Code: _____

Diagnosis Title/Narrative: _____

DATE ASSIGNMENT/CHANGE OF DIAGNOSIS TOOK PLACE: _____

Form Completed by: _____ Date: _____
(Signature Service Provider/Licensure/Designation)

Co-signature: _____ Date: _____
(Signature Service Provider/Licensure/Designation)

Data Entry Date: _____ Data Entry Initials: _____