State of California — Health and Human Services Agency

Department of Health Care Services
Substance Use Disorders Compliance Division
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

Incidental Medical Services Certification Form

Health Care Practitioner Client Assessment
For Alcoholism and Drug Abuse Recovery Treatment Services

I,___________________________________ have reviewed the client's initial screening questions prior to
(Health Care Practitioner Name) – Please Print

providing incidental medical services. I have also determined, based on the results of the questionnaire, that

___________________________________ is medically appropriate to receive incidental medical services at:
(Client Name)

____ located at:
(Provider Name)

____.
(Licensed Provider Address)

As a result of my assessment and the review of the client's medical health questionnaire, the above client requires and will receive the following alcoholism and drug abuse recovery treatment services (list services to be provided):

____

____

____

I also understand a copy of this form must be placed in the client's file prior to receiving incidental medical services. I further understand that I may receive treatment services by another healthcare practitioner associated with the above licensed residential facility.

Practitioner Name (please print): ____

Practitioner Signature: __________________________________ Date: ____________

Client Signature: ______________________________________ Date: ____________

By signing this form, I acknowledge that I have reviewed the client's medical health questionnaire and I am approving treatment services, as listed above.