REQUEST TO CHANGE MENTAL HEALTH PROVIDER

Name: _____

Request: _____

_____

_____

Reason

_____ I do not want to wait for my mental health provider's next available appointment

_____ I do not feel like my current mental health provider is a good fit/I don't like my current mental health provider

_____ My schedule conflicts with my current mental health provider's availability *(please provide specifics)*

_____ I am coming in for a different issue and I want to talk to a different mental health provider

_____ Other: _____

_____

I understand that this request will be reviewed by the Director/Clinical Director of Counseling Services. All requests will be responded to within 5 business days (or sooner). I understand that the Director/Clinical Director may contact me to discuss this request.

Signature_____ Date: _____

I can be reached at (phone number): _____

Date Received: _____

Reviewed By: _____

Approved (Y/N): _____