MACOMB COUNTY COMMUNITY MENTAL HEALTH

FOCUS DOCUMENT REMOVAL REQUEST

***REQUEST MADE BY:***

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| Person completing request (Name & Job Title): | | Date: |
| Location/Department: | Phone: | E-Mail Address: |
| Name & job title of person requesting removal if different from person completing request: | | |

***DOCUMENT INFORMATION:***

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| --- | --- |
| Consumer ID: | Consumer’s First & Last Name: |
| Document Service Date/Time (date service provided); for admissions, include provider, staff, and open/close date as applicable: | |
| Document Type:  □ Acknowledgment & Consent □ Annual Assessment (signed) □ Certificate of Need (CON)  □ Consent to Exchange Health Information □ Coordination of Care □ Discharge CSR  □ Initial Intake □ Injection/Dispense □ Lab Results  □ Life Events Checklist □ LOCUS □ MichiCANS □ Nursing Assessment PCP Meeting (specify): *o Full o Single Service o Crisis Team / Clubhouse / Medication Management*  □ PCP Pre-Planning Note □ PCP Goal(s) □ PCP Periodic Review □ PCP Addendum  □ Preliminary Plan of Service □ Prescription □ Progress Note (signed)  □ Psychiatric Evaluation □ Psychiatric O/P Office Visit (POOV) □ Transition Review Plan   * Scanned Document *(specify type & location/section):* * Other *(specify):* | |
| **Date/Time Document Added to FOCUS** (see ‘Record Added’ lower left corner of FOCUS): | |
| Reason Removal Requested: | |
| Supervisory Approval: (signature/date) | |
| **Submit by: Inter-office mail; Email: CentralRecordsShared@mccmh.net; US mail: MCCMH Clinical Records, 6555 15 Mile Road, Sterling Heights, MI 48312 OR fax: (586) 466-8719** | |

***MCCMH CLINCIAL RECORDS OFFICE USE ONLY:***

Requestor contacted? □ Date Contacted:

Comments:

MCCMH MCO Policy 2-018, Exhibit A, FOCUS Document Removal Request (rev. 12/24)