

24 Hour (Mode 05) SERVICE LOG

Activity Date: _____

DMH Contract Agency

Client ID#	Client Last Name & First Initial	Admit Date	Start Date	End Date	Discharge Date	Procedure Code	*EBP/SS	Ward	Authorization (For PDP Provider Only)	Claim Medi-Cal	Plan	¹ Screening Referral	² Pregnancy	³ Emergency	⁴ SED	⁵ SOC	Type of Admission	Patient Status Code
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
										<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Rendering Provider: _____ Date Received: ____/____/____ Entered By: _____

Signature

Share of Cost information was completed by designated staff other than Rendering Provider _____

Name

Signature

1. Screening Referral: For EPSDT clients, check this box if the Agency of Primary Responsibility is other than code 7 (None).
2. Pregnancy: For clients with Pregnancy or Pregnancy/Emergency Aid Code, check this box if the client is pregnant.
3. Emergency: For clients with Emergency or Pregnancy/Emergency Aid Code, check this box if the service is a crisis intervention, crisis stabilization, or emergency medication support.
4. SED-Serious Emotional Disturbance: For clients with Healthy Families, check this box if the child meets the definition of (SED).
5. SOC-Share of Cost: For clients with a Share of Cost, check this box. If checked, an eligibility check must be run.

* A list of codes can be found in the IS Codes Manual located at: <http://dmh.lacounty.gov/hipaa/index.html>

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Provider #: _____ Rendering Provider: _____ Staff Code: _____
Los Angeles County – Department of Mental Health