

**Oneida County Department of Mental Health
Case Review Request**

Facility / Agency Requesting: _____

Date of Request: _____

Patient: Last Name: _____ First Name: _____

DOB: _____

Reason for Referral: _____

Agencies Involved: _____

Request for Exam Form Attached: _____ Yes _____ No _____ N/A

Requestor Name (print): _____ Contact #: _____

(signature): _____

Fax to: OCDMH – Fax # 798-6445
 Herkimer County – Fax #867-1469

Date of Case Review: _____

Outcome: _____

