MACOMB COUNTY COMMUNITY MENTAL HEALTH

Substance Use Services

FOCUS DOCUMENT REMOVAL REQUEST

AGENCY REQUEST:

Person completing request (Name & Job Title):		Date:
Location:	Phone:	E-mail:

DOCUMENT INFORMATION:

FOCUS ID:	Client First & Last Name:
Document Date (date document added)	
Document Type: Admission [ ] Admission Layer [ ] Discharge [ ] Reverse Administrative Discharge [ ] Authorization [ ]	
Date/Time Record added to FOCUS (See 'Record Added' lower left corner of FOCUS):	
Reason Removal Requested:	

E-mail completed form to: Nicole.palazzolo@mccmh.net.

MCCMH - SUD STAFF OFFICE USE ONLY:

MCCMH – SUD Staff only: Removal Completed [ ]
Staff completing removal: _____ Date Completed: _____