To type in data, click on the grey shaded box.

Department of Public Health
City and County of San Francisco
Behavioral Health Services

Avatar Correction Request Form

Complete only portions relevant to your request.

Request Date:	
Requestor Name:	
Phone Number:	
E-Mail:	

Return completed form by Fax to 628-206-7517 or email to: svc.dph_bhsroi@sfdph.org

Program Name:	**Reporting Unit Number:**
Clinician Name:	**Staff ID:**
Client Last Name:	**Client First Name:**
Client ID/BIS:	**Date of Birth:**
Episode Number:	

Merge	**BIS Number**	**Other versions of Client Name (if applicable)**		**BIS Number**	**Other versions of Client Name (if applicable)**
Duplicate #1			**Duplicate #4**		
Duplicate #2			**Duplicate #5**		
Duplicate #3			**Duplicate #6**		

Assessment / Reassessment			
Date of Assessment:			
Type of Assessment	**(e.g. CANS CYF Initial Assessment, A/OA (short) w/ANSA Ratings, Psych Eval)**		
If requesting to move from one episode to another (for same client) complete the following			
Move from episode:		**Move to episode:**	
Wrong Client Name:	**If information was entered in wrong client record**		
Reason for Correction:			

Treatment of Plan of Care (POC)			
Date of POC:			
Indicate CYF or AOA:			
If requesting to move from one episode to another (for same client) complete the following			
Move from episode:		**Move to episode:**	
Wrong Client Name:	**If information was entered in wrong client record**		
Reason for correction:			

Progress Note * For Duplicate Note Deletions, staff must provide specifics of note to be deleted: 1) **DATE** and 2) **TIME** of when note was written									
Service Date:		**Procedure Code:**		**Duration:**		**Note Date:**		**Note Time:**	
Reason for correction:									

Other (specify)	
Date of Document:	
Reason for correction:	

***** **NOTE**: These procedures only correct the information in the clinical record. You may also need to correct billing/claims information via regular procedure.