pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

Request to Rescind Outpatient Competency Evaluation Referral - Rev. March 2022

Date: _____

Name of Individual
to be Evaluated: _____

Referring Agency: _____

Date of Original Referral : _____

Current Charges: _____

Reason for Rescinding Original Request:

Alternative Treatment: _____

Contact Name, E-mail &
Phone Number: _____

Signature & Date: _____

**Note: You do not need to physically sign this form, typing your name and date in the signature box is acceptable.

***Please e-mail completed form to: RA-OMHSASAssess@pa.gov.