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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| نموذج معلومات العميل | | | | | | | | | | | | | | | | | | | | |
| **CLIENT INFORMATION FORM (ARABIC)** | | | | | | | | | | | | | | | | | | | | |
| **DIVISION:**  AOABH  CYBH  PEI | | | | | | | | | | | | **FACILITY:** | | | | | | | | |
| **Date:** | | | | | | | | | | | | **INTAKE**  **UPDATE** | | | | | | | | |
| **المرجو استيفاء البيانات بخط واضح على قدر الإمكان و بالتفصيل** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| وليّ الأمر  Guardian | الأب/الأم  Parent | | | | | | | | العميل  Client | | | | | | **الشخص الذي يعبي بيانات الاستمارة:**  Person Filling Out Form: | | | | | |
| غير ذلك  Other | | | | | | | | | الطبيب/الطبيب النفسي  Clinician | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | |  | | | | | | |  | | |  | | | | |
| الاسم الاوسط  Middle Name | | | |  | الاسم الاول  First Name | | | | | | | |  | | | اسم العائلة  Last Name | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | |  |  | | | | | |  | | |  | | | |
| الاسم الممنوح عند الميلاد  مثل المذكور اعلاه  Same as Above Birth Name | | | | | | |  | الاسم قبل الزواج  Maiden Name | | | | | |  | | | الاسم الذي تحبذ ان تدعى به  Name You Prefer to Be Called | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **هل انت شخصياً او احد افراد عائلتك خدم في الجيش؟**  Have you or an immediate family member ever served in the US Military? | | | | | | | | | | | | | | | | | | | | |
| **تعريف العائلة من الدرجة الأولى: والد(ة)، شقيق(ة)، ابن(ة) (ولادة/تبنّي/ربيب)** | | | | | | | | | | | | | | | | | | | | |
| **انا شخصيّاً و احد افراد عائلتي**  Both Self & Immediate Family | | | | | | | | | | **قريب من الدرجة الأولى**  Immediate Family | | | | | | | | | **انا شخصياً فقط**  Self Only | |
| **غير معلوم**  Unknown | | | | | | | | | | **ممتنع عن التحديد**  Decline to State | | | | | | | | | **لا احد**  None | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | | | | | | | |  | | | | | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | |
|  | |  | | | | | |
|  | | رقم الضمان الاجتماعي  Social Security Number | | | | | | | | | |  | | | | | | تاريخ الميلاد  Date of Birth | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **جنس**  Gender | | | | | | | | | | | | | | | | | | | | |
| من ذكر إلى أنثى  Male to Female | | | من أنثى إلى ذكر  Female to Male | | | | | | | | المتحولين جنسيا: | | | | | | ذكر  Male | | | أنثى  Female |
| **غير ذلك**  Other | | | | | | | | | | | ممتنع عن التحديد  Decline to State | | | | | | | | | غير معلوم  Unknown |
|  | | | | | | | | | | | | | | | | | | | | |
| **التوجه الجنسي**  Sexual Orientation | | | | | | | | | | | | | | | | | | | | |
| مِثليه  Lesbian | | | متباين الجنس  Heterosexual | | | | | | | | مِثلي الجنس  Gay | | | | | | | | | ثنائي الجنس  Bisexual |
| غير ذلك  Other | | | | | | | | | | | ممتنع عن التحديد  Decline to State | | | | | | | | | مستفهم الجنس  Questioning |

|  |  |  |  |  |  |  |  |
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| **الضمائر الجنسية المفضلة**  Preferred Gender Pronouns | | | | | | | |
| **هم/إياهم/خاصتهم**  They / Them / Theirs | **هي/إياها/خاصتها**  She / Her / Hers | | | | | | **هو/إياه/خاصته**  He / Him / His |
| غير ذلك  Other | | | | | | | **ممتنع عن التحديد**  Decline to State |
|  | | | | | | | |
| نعم  Yes | | لا  No | | | | **هل استخدمت اسماء اخرى من قبل؟**  Have You Gone by Other Names in the Past? | |
|  | | | | | | | |
|  | | |  | |  | | | |
| الاسم الذي كنت تدعى به ثانياً (العائلي، الاول، الاوسط)  Previous Name #2 (Last, First, MI) | | |  | الاسم الذي كنت تدعى به اولاً (العائلي، الاول، الاوسط)  Previous Name #1 (Last, First, MI) | | | |

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| *CLIENT DEMOGRAPHICS* | | | | | | | | | | | | | | | | | | | | | | **بيانات العميل** |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | |  | | | | |  | |  | | | | | |
| محل الإقامة الحالي  Where Are You Currently Living? | | | | | | | |  | | ولاية الاصدار  State of Issue | | | | |  | | رقم رخصة القيادة/بطاقة التعريف الصادرة من الولاية  Driver’s License / State ID Number | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | | | | | | | | | | | |
| شقة  الِوحدة  جناح  Suite Unit Apt | | |  | | عنوان المراسلة (شارع او صندوق البريد)  Mailing Address (Street or PO Box) | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | |  | | | | | | | |  |  | | | | |  |  | | | |
| المقاطعة التي تقيم فيها  County of Residence | |  | | الرمز البريدي  Zip | | | | | | | |  | الولاية  State | | | | |  | المدينة  City | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | | | | | | | | | | | |
| شقة  الِوحدة  جناح  Suite Unit Apt | | |  | | العنوان الذي تقيم فيه الآن  نفس عنوان المراسلة  Same as Mailing Address Street Address Where You Are Currently Living | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | |  | |  | | |  | |  | | | | | | |
|  | الرمز البريدي  Zip | | | | | | | |  | | الولاية  State | | |  | | المدينة  City | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | | | | | | | | |  |  | |
| هاتف العمل /رقم التوصيلة  Business Phone / Ext | | | | | |  | الهاتف المحمول  Cell Phone | | | | | | | | | | | | |  | رقم الهاتف المنزلي  Home Phone | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | | | | | | | | |  |  | |
| البلد التي ولدت فيها  Country of Birth | | | | | |  | ولاية الولادة في الولايات المتحدة  US State of Birth | | | | | | | | | | | | |  | تاريخ الميلاد  CA County of Birth | |

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| *LANGUAGE / RELIGION* | | | | | | | | | | | | | | | **اللغة/الديانة** | |
|  | | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | | | | | |
| اللغة الثانية  Secondary Language | | | | |  | | اللغة الاساسية  Primary Language | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | |  |  | | | | | | | | | | |
| لغة العائلة  Family Language | | | | |  | اللغة المفضلة  Preferred Language | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | |  | | لا اتكلم  None | | | | | محدود  Limited | | بطلاقة  Fluent | | |
| الديانة المحبذة  Religious Preference | | | | |  | | درجة اتقان التحدث باللغة الانجليزية  English Verbal Proficiency | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| *ETHNICITY* | | | | | | | | | | | | | الأصل العرقي | | | |
|  | | | | | | | | | | | | | | | | |
| غير معلوم  Unknown | | | لا  No | نعم  Yes | | | | **هل انت من اصل اسباني، هسباني، او لاتيني؟**  Are You Spanish, Hispanic or Latino? | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **اذكر صفتين تحددان الاصل العرقي. ضع "1" للأصلي و"2" للثانوي/للفرعي**  Please Indicate Up to Two Ethnicities That Best Describe You: **“1”** for Primary and **“2”** for Secondary | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| باكستاني  Pakistani | \_\_\_ | هوائي الأصل  Hawaiian Native | | | | | | | | \_\_\_ | أليوتيّ  Aleut | | | | | \_\_\_ |
| فلسطني  Palestinian | \_\_\_ | هسباني غير: حددـــــــــــــــــــ  Hispanic-Other | | | | | | | | \_\_\_ | جزائري  Algerian | | | | | \_\_\_ |
| من بورتوريكو  Puerto Rican | \_\_\_ | هندي (اسيوي)  Indian (Asian) | | | | | | | | \_\_\_ | أميريجيان  Amerasian | | | | | \_\_\_ |
| من ساموا  Samoan | \_\_\_ | ايراني  Iranian | | | | | | | | \_\_\_ | بنغلاديشي  Bangladeshi | | | | | \_\_\_ |
| صومالي  Somalian | \_\_\_ | عراقي  Iraqi | | | | | | | | \_\_\_ | اسود/امريكي من اصل افريقي  Black / African-American | | | | | \_\_\_ |
| من أمريكا الجنوبية أوالوسطى  South or Central American | \_\_\_ | ياباني  Japanese | | | | | | | | \_\_\_ | كمبودي  Cambodian | | | | | \_\_\_ |
| اسباني  Spanish | \_\_\_ | كوري  Korean | | | | | | | | \_\_\_ | قوقازي/ أوروبي/ أبيض  Caucasian/European/White | | | | | \_\_\_ |
| من سري لانكا  Srilankan | \_\_\_ | لاوسي  Laotian | | | | | | | | \_\_\_ | صينى  Chinese | | | | | \_\_\_ |
| تايلاندي  Thai | \_\_\_ | لبناني  Lebanese | | | | | | | | \_\_\_ | من كوبا  Cuban | | | | | \_\_\_ |
| فيتنامي  Vietnamese | \_\_\_ | مكسيكي  Mexican | | | | | | | | \_\_\_ | مصري  Egyptian | | | | | \_\_\_ |
| **غير معلوم**  Unknown | \_\_\_ | من خذر امريكية اصلية  Native American | | | | | | | | \_\_\_ | اسكيمو  Eskimo | | | | | \_\_\_ |
| ممتنع عن التحديد  Decline to State | \_\_\_ | اسيوي آخر  Other Asian | | | | | | | | \_\_\_ | فلبيني  Filipino | | | | | \_\_\_ |
| غير ذلك  Other | \_\_\_ | من جزر المحيط الهادئ  Pacific Islander | | | | | | | | \_\_\_ | غواميني  Guamanian | | | | | \_\_\_ |
| ليس من هوائي/جوام/سامووا  (Not Hawaiian / Guamanian / Samoan) | | | | | | | | |  | | | | | | | |

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| *FAMILY INFORMATION* | | | | | | | | | | | | | | | | | | | **معلومات عن العائلة** | |
|  | | | | | | | | | | | | | | | | | | | | |
| الحالة الزوجية للعميل  Client Marital Status | | | | | | | | | | | | | | | | | | | | |
| **منفصل**  Separated | | | | | **مطلق**  Divorced | | | | | **متزوج**  Married | | | | | | | | **غير مرتبط**  Single | | |
|  | | | | | **الشراكة المحلية في المعيشة**  Domestic Partnership | | | | | | | | | | | | | **ارمل/ارملة**  Widowed | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **حتّى عمر ١٧**  Through Age 17 | | | | | | | أنت تعتبر الراعي الأساسي لكم عدد من الأشخاص؟  For how many people are you the Primary Caregiver? | | | | | | | | | | | | | |
| **١٨ أو أكبر**  18 or Older | | | | | | | **تعريف الراعي الأساسي: يأخذ ٥٠ % أو أكثر من وقتك** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | | | | | |  | |  | | | | | |
| الاسم الاوسط للأم  Mother’s Middle Name | | |  | الاسم الاول للأم  Mother’s First Name | | | | | | | | |  | | الاسم العائلي للأم  Mother’s Last Name | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | |  | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | | | | | |  |  | | | | | | |
|  | | |  | تاريخ ميلاد الأم  Mother’s Date of Birth | | | | | | | |  | | اسم الأم قبل الزواج  Mother’s Maiden Name | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | | | | | |  | |  | | | | | |
| الاسم الاوسط للأب  Father’s Middle Name | | |  | الاسم الاول للأب  Father’s First Name | | | | | | | | |  | | الاسم العائلي للأب  Father’s Last Name | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| *CLIENT EMPLOYMENT INFORMATION* | | | | | | | | | | | | | | | | | **معلومات عن وظيفة العميل** | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **يرجى تحديد الخيار الأكثر دقّة الذي يصف حالتك الوظيفية الحالية**  Please select the option that best describes your current employment status: | | | | | | | | | | | | | | | | | | | | |
| طالب  Student | غير تنافسي، دوام كامل (>٣٤ ساعة/الأسبوع)  Non-Competitive F/T (>34hrs/wk) | | | | | | | | | | تنافسي، دوام كامل (>٣٤ ساعة/الأسبوع)  Competitive F/T (>34hrs/wk) | | | | | | | | | |
| رب/ربة منزل  Homemaker | غير تنافسي، نصف دوام (<٣٤ ساعة/الأسبوع)  Non-Competitive P/T (<34hrs/wk) | | | | | | | | | | تنافسي، نصف دوام (<٣٤ ساعة/الأسبوع)  Competitive P/T (<34hrs/wk) | | | | | | | | | |
| غير ذلك  Other | | مقيم/سجين  Resident / Inmate | | | | باحث بجدية عن عمل  Actively Looking | | | | | | | | | | متطوّع  Volunteer | | | | متقاعد  Retired |
| **تعريف الوظيفة التنافسية والغير تنافسية:**  الوظيفة التنافسية =**وظيفة مدفوعة الأجر في المجتمع وهذه الوظيفة متاحة أيضاً للأفراد اللذين لا يعانون من إعاقات. قد تشمل هذه المجموعة وظائف فيها خدمات دعم مستمرة لها علاقة بالوظيفة داخل أو خارج مكان العمل (وظائف مدعومة).**  الوظائف الغير تنافسية = **وظائف مدفوعة الأجر في المجتمع وهذه الوظائف متاحة فقط للأفراد اللذين يعانون من إعاقات.** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  |  | | | | | | | | | | | |
| صاحب العمل  Employer | | | | | | | |  | الوظيفة  Occupation | | | | | | | | | | | |

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| *CLIENT SCHOOL INFORMATION* | | | | | | | | | | | | | | **معلومات مدرسة العميل** | |
|  | | | | | | | | | | | | | | | |
| **أعلى مستوى دراسي تم الحصول عليه**  Highest Education Completed: | | | | | | | | | | | | | | | |
| الصف الخامس  5th Grade | الصف الرابع  4th Grade | | | | الصف الثالث  3rd Grade | | الصف الثاني  2nd Grade | | | | الصف الأول  1st Grade | | | | الحضانة  Kindergarten |
| الصف الحادي عشر  11th Grade | الصف العاشر  10th Grade | | | | الصف التاسع  9th Grade | | الصف الثامن  8th Grade | | | | الصف السابع  7th Grade | | | | الصف السادس  6th Grade |
| درجة المنتسبين  Associate Degree | | السنة الأولى في الجامعة  1st Year College | | | | | | الصف الثاني عشر (ثانوية عامة أو ثانوية صناعية)  12th Grade (HS Grad or GED) | | | | | | | |
| درجة الماجستير  Master’s Degree | | السنة الأولى في الدراسات العليا  1st Year Grad Work | | | | | | درجة البكالوريوس  Bachelor’s Degree | | | | | السنة الثالثة في الجامعة  3rd Year College | | |
| غير ذلك  Other | | **غير معلوم**  Unknown | | | | **لا احد**  None | | درجة الدكتوراه  Doctorate | | | | السنة الثالثة في الدراسات العليا  3rd Year Grad Work | | | |
|  | | | | | | | | | | | | | | | |
|  | | |  |  | | | | |  |  | | | | | |
| رقم هاتف الشخص  Contact’s Phone Number | | |  | اسم شخص مسئول في المؤسسة التعليمية يمكننا الاتصال به  Name of School Contact | | | | |  | اسم المؤسسة التعليمية الملتحق بها  Name of School Attending | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *GENERAL MEDICAL CONDITIONS* | | | **الحالات الطبية العامة** | |
|  | | | | |
| يرجى الإشارة إلى أي حالة طبية عامة. ضع "1" للحالات الأساسية و "2" للحالات الثانوية  ضع علامة اختيار بجوار أية حالات طبية عامة إضافية إذا كان لديك أكثر من حالتين (2).  Please Indicate Any General Medical Conditions: List **“**1**”** for Primary and **“**2**”** for Secondary.  Place a check mark next to any additional General Medical Conditions if you have more than two (2). | | | | |
| متلازمة النفق الرسغي  Carpal Tunnel Syndrome | \_\_\_\_ | المريض ينفي أي حالات طبية  Patient Denies Any Medical Conditions | | \_\_\_\_ |
| مرض الانسداد الرئوي المزمن (COPD)  Chronic Obstructive Pulmonary Disease (COPD) | \_\_\_\_ | الحساسية  Allergies | | \_\_\_\_ |
| التليف الكبدي  Cirrhosis | \_\_\_\_ | فقر الدم  Anemia | | \_\_\_\_ |
| الاضطرابات الخلقية  Congenital Disorders | \_\_\_\_ | تصلب الشرايين  Arterial Sclerotic Disease | | \_\_\_\_ |
| فشل القلب الاحتقاني  Congestive Heart Failure | \_\_\_\_ | الربو  Asthma | | \_\_\_\_ |
| التليف الكيسي  Cystic Fibrosis | \_\_\_\_ | آلام الظهر / الرقبة  Back / Neck Pain | | \_\_\_\_ |
| الصمم/ضعف السمع  Deaf / Hearing Impaired | \_\_\_\_ | العمى/ضعف البصر  Blind / Visually Impaired | | \_\_\_\_ |
| الخرف  Dementia | \_\_\_\_ | اضطراب الدم (بخلاف فقر الدم)  Blood Disorder (other than Anemia) | | \_\_\_\_ |
| اضطراب الجلد/الآفات الجلدية  Dermatologic Disorder / Skin Lesions | \_\_\_\_ | السرطان  Cancer | | \_\_\_\_ |

تابع في الصفحة التالية

|  |  |  |  |
| --- | --- | --- | --- |
| ضمور العضلات  Muscular Dystrophy | \_\_\_\_ | داء السكري  Diabetes | \_\_\_\_ |
| مشكلة العضلات والعظام (ليس الظهر/الرقبة)  Musculoskeletal Problem (not back / neck) | \_\_\_\_ | اضطراب الجهاز الهضمي  Digestive Disorder | \_\_\_\_ |
| الاضطراب العصبي  Neurologic Disorder | \_\_\_\_ | التهاب الأذن  Ear Infections | \_\_\_\_ |
| البدانة  Obesity | \_\_\_\_ | اضطراب الغدد الصماء  Endocrine Disorder | \_\_\_\_ |
| الفصال العظمي  Osteoarthritis | \_\_\_\_ | الصرع/النوبات  Epilepsy / Seizures | \_\_\_\_ |
| هشاشة العظام  Osteoporosis | \_\_\_\_ | مشاكل المرارة  Gall Bladder Problems | \_\_\_\_ |
| الألم (المزمن)  Pain (Chronic) | \_\_\_\_ | اضطراب الجهاز البولي التناسلي  Genitourinary Disorder | \_\_\_\_ |
| مرض الشلل الرعاش  Parkinson’s Disease | \_\_\_\_ | ارتجاع المريء المُعدي  GERD | \_\_\_\_ |
| الإعاقة الجسدية  Physical Disability | \_\_\_\_ | الصداع) غير الصداع النصفي(  Headaches (not Migraines) | \_\_\_\_ |
| الصدفية  Psoriasis | \_\_\_\_ | مرض القلب  Heart Disease | \_\_\_\_ |
| الفشل الكلوي/مرض  Renal Failure / Disease | \_\_\_\_ | التهاب الكبد  Hepatitis | \_\_\_\_ |
| التهاب المفاصل الروماتيزمي  Rheumatologic Arthritis | \_\_\_\_ | ارتفاع الكولسترول  Hypercholesterolemia | \_\_\_\_ |
| الاضطراب الروماتيزمي  Rheumatologic Disorder | \_\_\_\_ | الدهون  Hyperlipidemia | \_\_\_\_ |
| المرض المنقول بالاتصال الجنسي (STD)  Sexually Transmitted Disease (STD) | \_\_\_\_ | ارتفاع ضغط الدم  Hypertension | \_\_\_\_ |
| السكتة الدماغية  Stroke | \_\_\_\_ | زيادة نشاط الغدة  Hyperthyroid | \_\_\_\_ |
| طنين الأذن  Tinnitus | \_\_\_\_ | القصور الدرقي  Hypothyroid | \_\_\_\_ |
| قرحة المعدة  Ulcers | \_\_\_\_ | الاضطراب المناعي  Immunologic Disorder | \_\_\_\_ |
| نقص الوزن  Underweight | \_\_\_\_ | العقم  Infertility | \_\_\_\_ |
| غير ذلك  Other | \_\_\_\_ | الصداع النصفي  Migraines | \_\_\_\_ |
| غير معروف / غير قادر على التقييم  Unknown / Not Able to Assess | \_\_\_\_ | التصلب المتعدد  Multiple Sclerosis | \_\_\_\_ |

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| *REFERRAL INFORMATION* | | | | | | | | | | | | **بيانات عن المرجع** | |
|  | | | | | | | | | | | | | |
| كيف تعرفت على خدماتنا؟  How did you find out about our services? | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| *EMERGENCY CONTACTS* | | | | | | | | | | | **التواصل في حالة الطوارئ** | |
| *Who should we contact in case of an emergency?* | | | | | | | | من يمكننا الاتصال به في حالة الطوارئ؟ | | | | |
|  | | | | | | | | | | | | |
| **الشخص الأولي (صلة العميل بهذا الشخص)**  Primary - Client’s Relationship to Emergency Contact | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | |
| العنوان  Address | | | | | |  | الاسم (العائلي، الاول)  Name (Last, First) | | | | | |
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|  |  | |  | | |  |  | | | | | |
| الرمز البريدي  Zip |  | | الولاية  State | | |  | المدينة  City | | | | | |
|  | | | | | | | | | | | | |
|  | | | |  |  | | | |  |  | | |
| رقم الهاتف المنزلي  Home Phone | | | |  | هاتف العمل /رقم التوصيلة  Business Phone / Ext. | | | |  | الهاتف المحمول  Cell Phone | | |
|  | | | | | | | | | | | | |
| **الشخص الثانوي (صلة العميل بهذا الشخص)**  Secondary - Client’s Relationship to Emergency Contact | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | |
| العنوان  Address | | | | | |  | الاسم (العائلي، الاول)  Name (Last, First) | | | | | |
|  | | | | | | | | | | | | |
|  | |  |  | | |  |  | | | | | |
| الرمز البريدي  Zip | |  | الولاية  State | | |  | المدينة  City | | | | | |
|  | | | | | | | | | | | | |
|  | | | |  |  | | | |  |  | | |
| رقم الهاتف المنزلي  Home Phone | | | |  | هاتف العمل /رقم التوصيلة  Business Phone / Ext. | | | |  | الهاتف المحمول  Cell Phone | | |

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| *CONSERVATORSHIP* | | | | | | | | | | | | | | | **الوصاية** |
|  | | | | | | | | | | | | | | | |
| هل انت تحت الوصاية؟ نعم  لا  **غير معلوم**  Are You on Conservatorship? Yes No Unknown | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | علاقة العميل بالوصيّ  Client Relationship to Conservator | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | |  |  | |
| الاسم الاوسط للوصيّ  Conservator Middle Name | | | | | |  | الاسم الاول للوصيّ  Conservator First Name | | | | | |  | الاسم العائلي للوصيّ  Conservator Last Name | |
|  | | | | | | | | | | | | | | | |
|  | | |  |  | | | | | | | | | | | |
| شقة  الِوحدة  جناح  Suite Unit Apt | | |  | عنوان المراسلة للوصيّ (شارع او صندوق البريد)  Conservator Mailing Address (Street or PO Box) | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  |  |  | | | | | | | |  |  | | | | |
| الرمز البريدي  Zip |  | الولاية  State | | | | | | | |  | عنوان المراسلة للوصيّ ـ المدينة  Conservator Mailing Address City | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | |  |  | |
| رقم الهاتف المنزلي  Home Phone | | | | |  | | هاتف العمل /رقم التوصيلة  Business Phone / Ext. | | | | | |  | الهاتف المحمول  Cell Phone | |
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| رقم الحالة المسجلة في المحكمة  Court Case Number | | | | | | | |  | **هل الوصيّ خاص ام معين من قبل هيئة عامة؟**  Is Conservator PAPG or Private? | | | | | | |
|  | | | | | | | | | | | | | | | |

**قف**

آخر صفحتين لموظفى العيادة فقط.

يرجى اعادة هذه الأواق لموظفى المكتب الأمامي.

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| **FOR CLINICIAN USE ONLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CLIENT DEMOGRAPHICS** | | | | | | | | | | | | | | | | | **Admission Living Arrangement** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1-12 (Group Home Level)  13-14 (Group Home Level)  Acute Psychiatric Inpatient  Board and Care  Cerritos College Hospital  Coastal Community Hospital  Convalescent Home  Costa Mesa College Hospital  Daily Support Req in House/Apt  Extended Care West Anaheim  Extended Care Westminster  Foster Care  Homeless/No Identifiable Res.  IMD (Institution for Mental Disease) | | | | | | | | | | | | | | | | | | | Jail/Correctional Facility  JH (Juvenile Hall)  Joplin Youth Camp  Kaiser Hospital  Medical Hospital  MHRC (MH Rehab Center)  No Support Req in House/Apt  Non-Contracted Facility  OCFC (Orangewood)  Out of State Res Tx Center  Parent/Guardian Home (Minor)  Prison  Psychiatric Hospital - Other  Psychiatric Residential Tx Center | | | | | | | | | | | | | | | | | | Regional Center Group Home  Residential/Recovery Facility  Res Rehabilitation Facility  RFE (Res Facility for the Elderly)  Room and Board  RTRC (Santa Ana Royale)  Shelter  SNF (Skilled Nursing)  Sober Living Home  Social Rehab Facility  Some Support Req in House/Apt  State Hospital  STEPs MHRC  STEPs Res Rehab Facility | | | | | | | | | Supported Housing  UCI Med Center  VA Hospital  WMA (West Med – Anaheim)  YGC (Youth Guidance Center)  YLA (Youth Leadership Academy)  Unknown/Not Reported  Other: | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SCHOOL INFORMATION** | | | | | | | | | | | | | | | | | | For Educationally Related Mental Health Services (ERMHS) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ERMHS Referral**: | | | | | | No | | | | | Yes | | | | | | | | | | **Home School District:** | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Special Education Eligibility** (per IEP) | | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Autism | | Deaf-Blind | | | | | | | | | | | | | | | | | Deaf/Hard of Hearing | | | | | | | | | | | | | | | | | Developmental Delays (Ages 3-9) | | | | | | | | | | Emotionally Disturbed | | | | | |
| Limited IQ | | | | | | | | | | | | | | | | | | | Non-Cat/Med Condition (0-5) | | | | | | | | | | | | | | | | | Orthopedically Impaired | | | | | | | | | | Other Health Impaired | | | | | |
| Specific Learning Disability | | | | | | | | | | | | | | | | | | | Speech & Language Impaired | | | | | | | | | | | | | | | | | Traumatic Brain Injury | | | | | | | | | | Visually Impaired | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Special Education Setting** (per IEP) | | | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Instruction | | | | | | | | Non-Public School | | | | | | | | | | | | | | | | | Regular Classroom | | | | | | | | | | RSP (Resource Specialized Program) | | | | | | | | | | | | SDC (Special Day Class) | | | | |
| State School | | | | | | | | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ENCOUNTER INFORMATION** | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Program Specialty** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **BHS Special Population** | | | | | | | | | | | | **CalWORKS** | | | | | | | | | | | | | | | **None** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TX TEAM INFORMATION** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HCA Providers** | | | (Last Name, First Name) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  |
| Psychiatrist / Nurse Practitioner | | | | | | | | | | | | | | | | | | | | | |  | | | | Medical Physician / Nurse Practitioner | | | | | | | | | | | | | | |  | | Care Coordinator / Case Manager | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  |
| Clinician | | | | | | | | | | | | | | | | | | | | | |  | | | | Auxiliary Service Provider | | | | | | | | | | | | | | |  | | Auxiliary Provider Type | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  |
| Service Chief / Program Director | | | | | | | | | | | | | | | | | | | | | |  | | | | CYS MHSA Tx Provider Type | | | | | | | | | | | | | | |  | |  | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LEGAL INFORMATION** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Court / Conservator Status** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| PC2974 | Probate 1400 | | | | | | | | | | | | | | W300 Juvenile Dependent | | | | | | | | | | | | | | | | | W5008 (Murphy Conservator) | | | | | | | | | | | | W5353 (Temp Conservator) | | | | | | | |
| W5358 LPS Conservator | | | | | | | | | | | | | | | W5686 | | | | | | | | | W601 Juvenile Status Ward | | | | | | | | | | | | | | | W602 Juvenile Ward | | | | | N/A | | | Unknown/Not Reported | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **W & I Code Legal Class** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other - Civil Involuntary Status | | | | | | | | | | | | | | Other - Criminal Involuntary Status | | | | | | | | | | | | | | | | | | | | PC1026 | | | | | | PC1370 | | PC2684 | | | | PC47.6, 47.8 | | |  | | |
| Sexual Psychopathy / Related Categories | | | | | | | | | | | | | | | | | | | | | | | W5150 | | | | | | W5250 | | | | | W5260 | | | | | | W5270.15 | | W5300 | | | | W5585 | | W6000 | | W709 | |
| N/A | | | | Unknown/Not Reported | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EOC INFORMATION** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EOC Start Date** | | | | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | **EOC Name** | | | | | | | | | | | | | | | | | | | | |

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| **FOR SAME DAY ADMISSION AND DISCHARGE** | | | | | |  | | | | | | | | |
| **Behavioral Health Treatment Linkage / Referral** | | | | | | |  | | | | | | | |
| ADAS Community Support | | | | | AMHS STEPs LPS | | | | | | | CYS Youth Resource Center | | |
| ADAS Medical Detox | | | | | AMHS STEPs MHRC | | | | | | | Domestic Violence Shelter | | |
| ADAS Outpatient | | | | | ASO (Administrative Services Organization) | | | | | | | Out of County Behavioral Health Service | | |
| ADAS Residential | | | | | CYS CAST | | | | | | | Non-Profit Organization | | |
| ADAS Social Detox | | | | | CYS CAT | | | | | | | PCP (Primary Care Physician) | | |
| AMHS Adult Outpatient Services | | | | | CYS CCPU | | | | | | | PEI OC CREW | | |
| AMHS Collaborative Court | | | | | CYS CEGU OCFC | | | | | | | Psychiatrist Private | | |
| AMHS Extended Care West | | | | | CYS CEGU Probation | | | | | | | Residential Tx Center for Children | | |
| AMHS Extended Care West Anaheim | | | | | CYS Contract Regional Outpatient | | | | | | | Student Health Service | | |
| AMHS FSP | | | | | CYS County Regional Outpatient | | | | | | | Therapist Private | | |
| AMHS LPS Unit (Lanterman - Petris - Short) | | | | | CYS CSP Children’s Residential Program | | | | | | | VA Health Care | | |
| AMHS Recovery Center | | | | | CYS FSP | | | | | | |  | | |
| AMHS OAS (Older Adult Services) | | | | | CYS Juvenile Drug Court | | | | | | | Client Declined Referral | | |
| AMHS PACT(Program Assertive Community Treatment) | | | | | CYS OC CAPC (In Home Crisis) | | | | | | | Client Unavailable for Referral | | |
| AMHS PACT TAY | | | | | CYS Phoenix Academy | | | | | | | N/A No Referral | | |
| AMHS Royale MHRC | | | | | CYS SCCS TAY Crisis Residential Program | | | | | | | Other | | |
| AMHS Royale TRC | | | | | CYS SCCS TAY Social Rehabilitation Program | | | | | | |  | | |
| AMHS SHOPP | | | | | CYS Touchstones | | | | | | |  | | |
|  | | | | | | | | | | | | | | |
| **Discharge Reason** | | | | | | | | | | | |  | | |
| Client Declined Services | Hospitalized | | | Linked to BHS Contract Provider | | | | | | Linked to BHS Provider | | | | Linked to non-BHS Provider |
| Does Not Meet Medical Necessity (NOA) | | | Does Not Meet Program Criteria | | | | | Other: | | | | | | |
|  | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
| **Facility EOC / Discharge Date** | | **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **EOC Name** | | ­­­­­­­­­­­­ | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **Office Staff** | | | | | |
| **Initials** | |  | | | |
| **Print / Type Name:** | | | | | | | | | **Date Processed:** | | | | **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | |