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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| فرم اطلاعات مراجع | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CLIENT INFORMATION FORM (FARSI)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DIVISION:**  AOABH  CYBH  PEI | | | | | | | | | | | | | | | **FACILITY:** | | | | | | | | | | | |
| **Date:** | | | | | | | | | | | | | | | **INTAKE**  **UPDATE** | | | | | | | | | | | |
| **لطفاً خوانا بنویسید و اطلاعات زیر را تا آنجا که میتوانید کامل کنید** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| قیم (سرپرست)  Guardian | پدر یا مادر  Parent | | | | | | | | | | مشتری (بیمار)  Client | | | | | | | | | **شخصی که فرم را پر میکند:**  Person Filling Out Form: | | | | | | |
| سایر موارد  Other | | | | | | | | | | | درمانگر  Clinician | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | |  | | | | | | | | | | |  | |  | | | | | |
| نام میانی  Middle Name | | | | | |  | نام  First Name | | | | | | | | | | | |  | | نام خانوادگی  Last Name | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | |  |  | | | | | |  |  | | | | | | | | | |
| نام در زمان تولد  همانند (اطلاعات) بالا  Same as Above Birth Name | | | | | | | | |  | نام خانوادگی قبل از ازدواج  Maiden Name | | | | | |  | نامی که دوست دارید به آن صدایتان کنند  Name You Prefer to Be Called | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **آیا خودتان و یا فردی از خانواده تان هیچوقت در ارتش خدمت کرده اید؟**  Have you or an immediate family member ever served in the US Military? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **تعریف خانواده درجه یک: پدر و مادر، خواهر و برادر، فرزند (از تولد/به فرزندی پذیرفته/فرزند خوانده)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **هم خود و هم خانواده درجه یک**  Both Self & Immediate Family | | | | | | | | | | | | **خانواده درجه یک**  Immediate Family | | | | | | | | | | | | **فقط خود شخص**  Self Only | | |
| **ناشناخته**  Unknown | | | | | | | | | | | | **نمیخواهم بگویم**  Decline to State | | | | | | | | | | | | **هیچ**  None | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | | | | | | | | | |  | | | | | | | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | |
|  | | |  | | | | | | | |
|  | | شماره تامین اجتماعی (شماره سوشال سکیوریتی)  Social Security Number | | | | | | | | | | | | | | | |  | | | | | تاریخ تولد  Date of Birth | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **جنسیت**  Gender | | | | | | | | | | | | | | | | | | | | | | | | | | |
| مذکر به مؤنث (مرد به زن)  Male to Female | | | | | مؤنث به مذکر (زن به مرد)  Female to Male | | | | | | | | | تراجنسی: | | | | | | | | مذکر (مرد)  Male | | | | مؤنث (زن)  Female |
| **سایر موارد**  Other | | | | | | | | | | | | | | نمیخواهم بگویم  Decline to State | | | | | | | | | | | | ناشناخته  Unknown |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **گرایش جنسی**  Sexual Orientation | | | | | | | | | | | | | | | | | | | | | | | | | | |
| لزبین  Lesbian | | | | دگر جنس گرا  Heterosexual | | | | | | | | | همجنس گرا  Gay | | | | | | | | | | | | دو جنس گرا  Bisexual | |
| سایر موارد  Other | | | | | | | | | | | | | نمیخواهم بگویم  Decline to State | | | | | | | | | | | | پرسشگر  Questioning | |

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| **کلمه ای که ترجیح میدهید از نظر جنسیت در مورد شما استفاده شود: آقای، خانم،**  Preferred Gender Pronouns | | | | | | | |
| **آنها / ایشان**  They / Them / Theirs | **او / وی (زن)**  She / Her / Hers | | | | | | **او / وی (مرد)**  He / Him / His |
| سایر موارد  Other | | | | | | | **نمیخواهم بگویم**  Decline to State |
|  | | | | | | | |
| بله  Yes | | نه  No | | | | **آیا در گذشته از نام دیگری استفاده کرده اید؟**  Have You Gone by Other Names in the Past? | |
|  | | | | | | | |
|  | | |  | |  | | | |
| نام قبلی شماره 2(نام خانوادگی، نام، نام میانی)  Previous Name #2 (Last, First, MI) | | |  | نام قبلی شماره 1(نام خانوادگی، نام، نام میانی)  Previous Name #1 (Last, First, MI) | | | |

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| *CLIENT DEMOGRAPHICS* | | | | | | | | | | | | | | | | | | | | | | **اطلاعات مربوط به مشتری (بیمار)** |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | |  | | | | |  | |  | | | | | |
| در حال حاضر کجا زندگی میکنید؟  Where Are You Currently Living? | | | | | | | |  | | ایالت صدور  State of Issue | | | | |  | | شماره گواهینامه/کارت شناسائی ایالتی  Driver’s License / State ID Number | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | |  | | | | | | | | | | | | | | | | |
| آپارتمان  واحد  شماره سوئیت  Suite Unit Apt | | | |  | | نشانی پستی (خیابان یا صندق پستی)  Mailing Address (Street or PO Box) | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | |  |  | | | | |  |  | | | |
| شهرستان (کانتی) محل اقامت  County of Residence | |  | کد پستی  Zip | | | | | | | | |  | ایالت  State | | | | |  | شهر  City | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | |  | | | | | | | | | | | | | | | | |
| آپارتمان  واحد  شماره سوئیت  Suite Unit Apt | | | |  | | نشانی خیابانی محلی که در حال حاضر زندگی میکنید  همانند نشانی پستی  Same as Mailing Address Street Address Where You Are Currently Living | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | |  | |  | | |  | |  | | | | | | |
|  | کد پستی  Zip | | | | | | | |  | | ایالت  State | | |  | | شهر  City | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | | | | | | | | |  |  | |
| شماره محل کار/شماره داخلی  Business Phone / Ext | | | | |  | | تلفن دستی  Cell Phone | | | | | | | | | | | | |  | تلفن منزل  Home Phone | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | | | | | | | | |  |  | |
| کشور محل تولد  Country of Birth | | | | |  | | ایالت محل تولد در ایالات متحده امریکا  US State of Birth | | | | | | | | | | | | |  | شهرستان (کانتی) محل تولد در کالیفرنیا  CA County of Birth | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *LANGUAGE / RELIGION* | | | | | | | | | | | | | | | **زبان / مذهب** | |
|  | | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | | | | | |
| زبان دوم  Secondary Language | | | | |  | | زبان اول (اصلی)  Primary Language | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | |  |  | | | | | | | | | | |
| زبان خانواده  Family Language | | | | |  | زبان ترجیحی شما  Preferred Language | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | |  | | هیچ  None | | | | | محدود  Limited | | مسلط  Fluent | | |
| مذهب مورد ترجیح  Religious Preference | | | | |  | | آشنائی به زبان گفتاری انگلیسی  English Verbal Proficiency | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| *ETHNICITY* | | | | | | | | | | | | | قومیت | | | |
|  | | | | | | | | | | | | | | | | |
| ناشناخته  Unknown | | | نه  No | بله  Yes | | | | **آیا اسپانیائی، هیسپانیک و یا لاتینو هستید؟**  Are You Spanish, Hispanic or Latino? | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| لطفاً دو قومیت که به بهترین وجهی شما را تعریف میکنند علامت بزنید: "1" اولیه و "2" ثانویه  Please Indicate Up to Two Ethnicities That Best Describe You: **“1”** for Primary and **“2”** for Secondary | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| پاکستانی  Pakistani | \_\_\_ | اهالی بومی هاوائی  Hawaiian Native | | | | | | | | \_\_\_ | آلوئت  Aleut | | | | | \_\_\_ |
| فلسطینی  Palestinian | \_\_\_ | هیسپانیک – سایر  Hispanic-Other | | | | | | | | \_\_\_ | الجزایری  Algerian | | | | | \_\_\_ |
| پورتوریکوئی  Puerto Rican | \_\_\_ | هندی (آسیائی)  Indian (Asian) | | | | | | | | \_\_\_ | آسیائی-آمریکائی  Amerasian | | | | | \_\_\_ |
| ساموآئی  Samoan | \_\_\_ | ایرانی  Iranian | | | | | | | | \_\_\_ | بنگلادشی  Bangladeshi | | | | | \_\_\_ |
| سومالیائی  Somalian | \_\_\_ | عراقی  Iraqi | | | | | | | | \_\_\_ | سیاه پوست / افریقائی-آمریکائی  Black / African-American | | | | | \_\_\_ |
| اهل آمریکای جنوبی یا مرکزی  South or Central American | \_\_\_ | ژاپنی  Japanese | | | | | | | | \_\_\_ | کامبوجی  Cambodian | | | | | \_\_\_ |
| اسپانیائی  Spanish | \_\_\_ | کره ای  Korean | | | | | | | | \_\_\_ | قفقازی/اروپائی/سفید پوست  Caucasian/European/White | | | | | \_\_\_ |
| سریلانکائی  Srilankan | \_\_\_ | لائوسی  Laotian | | | | | | | | \_\_\_ | چینی  Chinese | | | | | \_\_\_ |
| تایلندی  Thai | \_\_\_ | لبنانی  Lebanese | | | | | | | | \_\_\_ | کوبائی  Cuban | | | | | \_\_\_ |
| ویتنامی  Vietnamese | \_\_\_ | مکزیکی  Mexican | | | | | | | | \_\_\_ | مصری  Egyptian | | | | | \_\_\_ |
| **ناشناخته**  Unknown | \_\_\_ | بومی امریکائی  Native American | | | | | | | | \_\_\_ | اسکیمو  Eskimo | | | | | \_\_\_ |
| نمیخواهم بگویم  Decline to State | \_\_\_ | سایر آسیائی ها  Other Asian | | | | | | | | \_\_\_ | فیلیپینی  Filipino | | | | | \_\_\_ |
| سایر موارد  Other | \_\_\_ | اهالی جزایر اقیانوس آرام  Pacific Islander | | | | | | | | \_\_\_ | اهل گوام  Guamanian | | | | | \_\_\_ |
| (اهل هاوائی/گوام/ساموآ نیستید)  (Not Hawaiian / Guamanian / Samoan) | | | | | | | | |  | | | | | | | |

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| *FAMILY INFORMATION* | | | | | | | | | | | | | | | | | **اطلاعات در مورد خانواده** | | |
|  | | | | | | | | | | | | | | | | | | | |
| وضعیت ازدواج مشتری (بیمار)  Client Marital Status | | | | | | | | | | | | | | | | | | | |
| **از هم جدا شده**  Separated | | | | **طلاق گرفته**  Divorced | | | | | | **مزدوج (ازدواج کرده)**  Married | | | | | | | | **مجرد**  Single | |
| **مشارکت خانگی**  Domestic Partnership | | | | | | | | | | | | | | | | | | **بیوه**  Widowed | |
|  | | | | | | | | | | | | | | | | | | | |
| **در طی سن 17 سالگی**  Through Age 17 | | | | | | | | | برای چند نفر مراقب اولیه هستید؟  For how many people are you the Primary Caregiver? | | | | | | | | | | |
| **سال یا بیشتر 18**  18 or Older | | | | | | | | | **تعریف مراقب اولیه: %50 یا بیشتر از وقتتان** | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | |  | |  | | | | |
| نام میانی مادر  Mother’s Middle Name | | |  | | نام مادر  Mother’s First Name | | | | | | | |  | | نام خانوادگی مادر  Mother’s Last Name | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | |  | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | | | | |  |  | | | | | |
|  | | |  | | تاریخ تولد مادر  Mother’s Date of Birth | | | | | | |  | | نام خانوادگی مادر قبل از ازدواج  Mother’s Maiden Name | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | |  | |  | | | | |
| نام میانی پدر  Father’s Middle Name | | |  | | نام پدر  Father’s First Name | | | | | | | |  | | نام خانوادگی پدر  Father’s Last Name | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| *CLIENT EMPLOYMENT INFORMATION* | | | | | | | | | | | | | | | | | **اطلاعات اشتغال مراجع** | | |
|  | | | | | | | | | | | | | | | | | | | |
| **لطفأ گزینه ای که وضعیت اشتغال کنونی شما را بهتر تعریف مینماید را انتخاب فرمائید**  Please select the option that best describes your current employment status: | | | | | | | | | | | | | | | | | | | |
| محصل  Student | غیر هماوردی تمام وقت (>34 ساعت / هفته)  Non-Competitive F/T (>34hrs/wk) | | | | | | | | | | هماوردی تمام وقت (>34 ساعت / هفته)  Competitive F/T (>34hrs/wk) | | | | | | | | |
| خانه دار  Homemaker | غیر هماوردی پاره وقت (<34 ساعت / هفته)  Non-Competitive P/T (<34hrs/wk) | | | | | | | | | | هماوردی پاره وقت (<34 ساعت / هفته)  Competitive P/T (<34hrs/wk) | | | | | | | | |
| سایر موارد  Other | | بیمار / بستری  Resident / Inmate | | | | | جویندۀ کار  Actively Looking | | | | | | | | | داوطلب  Volunteer | | | بازنشسته  Retired |
| تعریف اشتغال هماوردی و غیر هماوردی  اشتغال هماوردی = **اشتغال با درامد در جامعه، در موقعیت شغلی که برای افراد بدون معلولیت نیز امکن پذیر است. این میتواند شامل مشاغلی با خدمات حمایتی در محل یا خارج از محل کار باشد. (اشتغال با پشتیبانی)**  اشتغال غیر هماوردی = **اشتغال با درامد در جامعه، که فقط دسترس افراد با معلولیت میباشد** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | |  | | | | | | | | | | | |
| کارفرما  Employer | | | | | |  | | شغل  Occupation | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *CLIENT SCHOOL INFORMATION* | | | | | | | | | | | **اطلاعات مربوط به مدرسه مشتری (بیمار)** | | | | | |
|  | | | | | | | | | | | | | | | | |
| **بالاترین سطح تحصیلی تکمیل شده**  Highest Education Completed: | | | | | | | | | | | | | | | | |
| کلاس پنجم  5th Grade | کلاس چهارم  4th Grade | | | کلاس سوم  3rd Grade | | | کلاس دوم  2nd Grade | | | | | | کلاس اول  1st Grade | | | مهد کودک  Kindergarten |
| کلاس یازهم  11th Grade | کلاس دهم  10th Grade | | | کلاس نهم  9th Grade | | | کلاس هشتم  8th Grade | | | | | | کلاس هفتم  7th Grade | | | کلاس ششم  6th Grade |
| فوق دیپلم  Associate Degree | | سال اول دانشگاه  1st Year College | | | | | | | کلاس دوازهم (دیپلمه دبیرستان یا GED)  12th Grade (HS Grad or GED) | | | | | | | |
| فوق لیسانس  Master’s Degree | | سال اول فوق لیسانس  1st Year Grad Work | | | | | | لیسانس  Bachelor’s Degree | | | | | | | سال سوم دانشگاه  3rd Year College | |
| **سایر موارد**  Other | | ناشناخته  Unknown | | | | **هیچ**  None | | | | دکترا  Doctorate | | | | | سال اول دکترا  3rd Year Grad Work | |
|  | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | |  | | |
| شماره تلفن فرد مورد تماس  Contact’s Phone Number | | |  | | نام طرف تماس در مدرسه  Name of School Contact | | | | | | |  | | نام مدرسه ای که به آن میروید  Name of School Attending | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *GENERAL MEDICAL CONDITIONS* | | | **شرایط عمومی پزشکی** | |
|  | | | | |
| لطفاً تمامی بیماری های عمومی را مشخص کنید: برای مورد اولیه عدد «1» و برای مورد ثانویه عدد «2» را قرار دهید  در صورت وجود بیش از دو (2) مورد، در کنار موارد اضافی علامت تیک بزنید.  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). | | | | |
| بیماری مزمن انسدادی ریه (COPD)  Chronic Obstructive Pulmonary Disease (COPD) | \_\_\_\_ | بیمار داشتن هرگونه مشکل پزشکی را انکار میکند  Patient Denies Any Medical Conditions | | \_\_\_\_ |
| سیروز  Cirrhosis | \_\_\_\_ | آلرژی  Allergies | | \_\_\_\_ |
| اختلالات مادرزادی  Congenital Disorders | \_\_\_\_ | کم خونی  Anemia | | \_\_\_\_ |
| نارسایی احتقانی قلب  Congestive Heart Failure | \_\_\_\_ | تصلب شرایین  Arterial Sclerotic Disease | | \_\_\_\_ |
| فیبروز سیستیک  Cystic Fibrosis | \_\_\_\_ | آسم  Asthma | | \_\_\_\_ |
| ناشنوا/کم شنوا  Deaf / Hearing Impaired | \_\_\_\_ | درد پشت / گردن  Back / Neck Pain | | \_\_\_\_ |
| زوال عقل  Dementia | \_\_\_\_ | نابینا / ناتوان از نظر بینائی  Blind / Visually Impaired | | \_\_\_\_ |
| اختلال/ضایعات‌ پوستی  Dermatologic Disorder / Skin Lesions | \_\_\_\_ | اختلالات خونی (به غیر کم‌خونی)  Blood Disorder (other than Anemia) | | \_\_\_\_ |
| دیابت  Diabetes | \_\_\_\_ | سرطان  Cancer | | \_\_\_\_ |
| اختلال گوارشی  Digestive Disorder | \_\_\_\_ | سندرم تونل کارپال  Carpal Tunnel Syndrome | | \_\_\_\_ |

بقیه در صفحۀ بعد

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| --- | --- | --- | --- |
| مشکل اسکلتی عضلانی (به غیر از پشت / گردن)  Musculoskeletal Problem (not back / neck) | \_\_\_\_ | عفونت گوش  Ear Infections | \_\_\_\_ |
| اختلال نورولوژیک  Neurologic Disorder | \_\_\_\_ | اختلال غدد درون ریز  Endocrine Disorder | \_\_\_\_ |
| چاقی  Obesity | \_\_\_\_ | صرع/تشنج  Epilepsy / Seizures | \_\_\_\_ |
| استئوآرتریت  Osteoarthritis | \_\_\_\_ | مشکلات کیسه صفرا  Gall Bladder Problems | \_\_\_\_ |
| پوکی استخوان  Osteoporosis | \_\_\_\_ | اختلال دستگاه ادراری تناسلی  Genitourinary Disorder | \_\_\_\_ |
| درد (مزمن)  Pain (Chronic) | \_\_\_\_ | بازگشت اسید به مری  GERD | \_\_\_\_ |
| بیماری پارکینسون  Parkinson’s Disease | \_\_\_\_ | سردرد (به غیر از میگرن)  Headaches (not Migraines) | \_\_\_\_ |
| معلولیت جسمی  Physical Disability | \_\_\_\_ | بیماری قلبی  Heart Disease | \_\_\_\_ |
| پسوریازیس  Psoriasis | \_\_\_\_ | هپاتیت  Hepatitis | \_\_\_\_ |
| نارسایی/بیماری کلیه  Renal Failure / Disease | \_\_\_\_ | هیپرکلسترولمی  Hypercholesterolemia | \_\_\_\_ |
| آرتریت روماتولوژیک  Rheumatologic Arthritis | \_\_\_\_ | هیپرلیپیدمی  Hyperlipidemia | \_\_\_\_ |
| اختلال روماتولوژیک  Rheumatologic Disorder | \_\_\_\_ | فشار خون بالا  Hypertension | \_\_\_\_ |
| بیماری های آمیزشی (STD)  Sexually Transmitted Disease (STD) | \_\_\_\_ | پرکاری تیروئید  Hyperthyroid | \_\_\_\_ |
| سکته مغزی  Stroke | \_\_\_\_ | کم کاری تیروئید  Hypothyroid | \_\_\_\_ |
| وزوز گوش  Tinnitus | \_\_\_\_ | اختلال دستگاه ایمنی  Immunologic Disorder | \_\_\_\_ |
| اولسرها  Ulcers | \_\_\_\_ | ناباروری  Infertility | \_\_\_\_ |
| کم بودن وزن  Underweight | \_\_\_\_ | میگرن  Migraines | \_\_\_\_ |
| سایر موارد  Other | \_\_\_\_ | ﻣﻮﻟﺘﯿﭙﻞ اﺳﮑﻠﺮوزﯾﺲ  Multiple Sclerosis | \_\_\_\_ |
| **نا معلوم / غیر قابل ارزیابی یا تشخیص**  Unknown / Not Able to Assess | \_\_\_\_ | دیستروفی ماهیچه ای  Muscular Dystrophy | \_\_\_\_ |

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| --- | --- |
| *REFERRAL INFORMATION* | **اطلاعات رجوع** |
|  | |
| در مورد خدمات ما از چه طریقی باخبر شدید؟  How did you find out about our services? | |

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| *EMERGENCY CONTACTS* | | | | | | | | | **فرد یا افراد برای تماس در مواقع اضطراری یا اورژانس** | | |
| *Who should we contact in case of an emergency?* | | | | | | در صورت وضعیت اضطراری یا اورژانس با چه کسی تماس بگیریم؟ | | | | | |
|  | | | | | | | | | | | |
| **فرد اصلی برای تماس** **(نسبت مشتری/بیمار با این فرد)**  Primary - Client’s Relationship to Emergency Contact | | | | | | | | | | | |
|  | | | | | | |  |  | | | |
| نشانی  Address | | | | | | |  | نام (نام خانوادگی، نام)  Name (Last, First) | | | |
|  | | | | | | | | | | | |
|  |  | |  | | | |  |  | | | |
| کد پستی  Zip |  | | ایالت  State | | | |  | شهر  City | | | |
|  | | | | | | | | | | | |
|  | | | |  |  | | | | |  |  |
| تلفن منزل  Home Phone | | | |  | شماره محل کار/شماره داخلی  Business Phone / Ext. | | | | |  | تلفن دستی  Cell Phone |
|  | | | | | | | | | | | |
| **فرد دوم برای تماس (نسبت مشتری/بیمار با این فرد)**  Secondary - Client’s Relationship to Emergency Contact | | | | | | | | | | | |
|  | | | | | | |  |  | | | |
| نشانی  Address | | | | | | |  | نام (نام خانوادگی، نام)  Name (Last, First) | | | |
|  | | | | | | | | | | | |
|  | |  |  | | | |  |  | | | |
| کد پستی  Zip | |  | ایالت  State | | | |  | شهر  City | | | |
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|  | | | |  |  | | | | |  |  |
| تلفن منزل  Home Phone | | | |  | شماره محل کار/شماره داخلی  Business Phone / Ext. | | | | |  | تلفن دستی  Cell Phone |

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| *CONSERVATORSHIP* | | | | | | | | | | | | | | | **سرپرستی قانونی** |
|  | | | | | | | | | | | | | | | |
| آیا تحت سرپرستی قانونی هستید؟ بله  نه  **ناشناخته**  Are You on Conservatorship? Yes No Unknown | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | نسبت مشتری (بیمار) با سرپرست قانونی  Client Relationship to Conservator | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | |  |  | |
| نام میانی سرپرست قانونی  Conservator Middle Name | | | | |  | | نام سرپرست قانونی  Conservator First Name | | | | | |  | نام خانوادگی سرپرست قانونی  Conservator Last Name | |
|  | | | | | | | | | | | | | | | |
|  | | |  | | |  | | | | | | | | | |
| آپارتمان  واحد  شماره سوئیت  Suite Unit Apt | | |  | | | نشانی پستی سرپرست قانونی (نشانی خیابان یا صندوق پستی)  Conservator Mailing Address (Street or PO Box) | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  |  |  | | | | | | | |  |  | | | | |
| کد پستی  Zip |  | ایالت  State | | | | | | | |  | نشانی پستی سرپرست قانونی - شهر  Conservator Mailing Address City | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | |  | | |  | | | | | |  |  | |
| تلفن منزل  Home Phone | | | |  | | | شماره محل کار/شماره داخلی  Business Phone / Ext. | | | | | |  | تلفن دستی  Cell Phone | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | |  |  | | | | | | |
| شماره پرونده دادگاه  Court Case Number | | | | | | | |  | **آیا سرپرستی قانونی دولتی ( PAPG ) یا خصوصی است؟**  Is Conservator PAPG or Private? | | | | | | |
|  | | | | | | | | | | | | | | | |

**توقف**

دو صفحه آخر فقط برای استفاده در کلینیک است. لطفاً این بسته را به کارکنان پذیرش بدهید.

**توقف**

دو صفحه آخر فقط برای استفاده در کلینیک است. لطفاً این بسته را به کارکنان پذیرش بدهید.

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| **FOR CLINICIAN USE ONLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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:** | | | | **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | |