|  |
| --- |
| **DATOS PERSONALES DEL CLIENTE** |
| **CLIENT INFORMATION FORM (SPANISH)** |
| **DIVISION:** [ ]  AOABH [ ]  BHCOE [ ]  CYBH  | **FACILITY:**  |
| **Date:**       |  [ ]  **INTAKE** [ ]  **UPDATE** [ ]  **SAME DAY REG / DC** |
| **(Por favor use letra de imprenta y llene el formulario lo mejor posible)** |
|  |
| **Persona que completa el formulario:**Person Filling Out Form: | **[ ]** Cliente Client | [ ]  Padre/Madre  Parent | [ ]  Tutor Guardian |
|  | [ ]  Médico Clinician | [ ]  Otro            Other  |
|  |
|       |  |       |  |       |
| ApellidoLast Name |  | Primer NombreFirst Name |  | Segundo NombreMiddle Name |
|  |
|       |  |       |  |       |
| Nombre PreferidoName You Prefer to Be Called |  | Nombre de SolteraMaiden Name |  | Apellido al Nacer [ ]  Igual que el de más arribaBirth Name Same as Above |
|  |
| **¿Ud. o su familia inmediata, han servido en el ejército de los EE. UU?**Have you or an immediate family member ever served in the US Military? |
| *Definición de Familia Inmediata: Padres, Hermanos, Hijos (biológico / adoptivo / hijastro)* |
| **[ ]**  Ud. Solo Self Only | **[ ]** Familia Inmediata Immediate Family | **[ ]**  Ud. y un miembro de su familia Both Self & Immediate Family |
| **[ ]** Nadie None | **[ ]** Prefiere No Contestar Decline to State | **[ ]** Desconocido Unknown |
|  |
| \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ |  |
|  |  |
| Fecha de NacimientoDate of Birth |  | Número de Seguro SocialSocial Security Number |  |
|  |
| **Género**Gender |
| [ ]  Fem Female | [ ]  Masc Male | Transsexual: | [ ]  Fem. a Masc. Female to Male | [ ]  Masc. a Fem Male to Female |
| [ ]  Desconocido Unknown | [ ]  Prefiere No Contestar Decline to State | [ ]  Otro            Other  |
|  |
| **Orientación Sexual**Sexual Orientation |
| [ ]  Bisexual Bisexual | [ ]  Gay  Gay | [ ]  Heterosexual Heterosexual | [ ]  Lesbiana Lesbian |
| [ ]  Dudoso Questioning | [ ]  Prefiere No Contestar Decline to State | [ ]  Otro            Other  |

|  |
| --- |
| **Pronombres de género preferido**Preferred Gender Pronouns |
| **[ ]** él, él, de él He / Him / His | **[ ]** ella, ella, de ella She / Her / Hers | **[ ]** ellos/as, ellos/as, de ellos/as They / Them / Theirs |
| **[ ]** Prefiere No Contestar Decline to State | [ ]  Otro            Other  |
|  |
| **¿Ha tenido otros nombres diferentes del actual?**Have You Gone by Other Names in the Past? | [ ]  No No | [ ]  Si Yes |
|  |
|       |  |       |
| Nombre anterior #1 ( Apellido, Nombres)Previous Name #1 (Last, First, MI) |  | Nombre anterior #2 (Apellido, Nombres)Previous Name #2 (Last, First, MI) |

|  |  |
| --- | --- |
| **DEMOGRAFIA DEL CLIENTE** | *CLIENT DEMOGRAPHICS* |
|  |
|       |  |       |  |       |
| Número de la Licencia de Conductor o Número de Identificación del EstadoDriver’s License / State ID Number |  | Estado donde le otorgaron la lic.State of Issue |  | ¿Dónde vive actualmente?Where Are You Currently Living?  |
|  |
|       |  |       |
| Dirección Postal (Calle ó Casilla de Correo)Mailing Address (Street or PO Box) |  | [ ]  Ap [ ]  Unidad [ ]  N° de Suite Apt Unit Suite # |
|  |
|       |  |    |  |       |  |       |
| CiudadCity | EstadoState | Código PostalZip | Condado de ResidenciaCounty of Residence |
|  |
|       |  |       |
| Dirección Actual [ ]  Igual que la de arribaStreet Address Where You Are Currently Living Same as Mailing Address |  | [ ]  Ap [ ]  Unidad [ ]  N° de Suite Apt Unit Suite # |
|  |
|       |  |       |  |       |  |
| CiudadCity |  | EstadoState |  | Código Postal Zip |
|  |
|       |  |       |  |       |
| Teléfono de CasaHome Phone |  | Teléfono CelularCell Phone |  | Teléfono del TrabajoBusiness Phone |
|  |
| **LUGAR DE NACIMIENTO** | *PLACE OF BIRTH* |
|  |
|       |  |       |  |       |
| Condado de nacimiento en CACA County of Birth |  | Estado de nacimiento en los EE.UU.US State of Birth |  | País donde NacióCountry of Birth |

|  |  |
| --- | --- |
| **IDIOMA / RELIGION** | *LANGUAGE / RELIGION* |
|  |
|        |  |       |
| Primer IdiomaPrimary Language |  | Segundo IdiomaSecondary Language |
|  |
|       |  |       |
| Idioma PreferidoPreferred Language |  | Idioma que Habla la FamiliaFamily Language |
|  |
|  [ ]  Lo domina Fluent | [ ]  Limitada Limited | [ ]  Ninguna None |  |        |
| Habilidad Verbal en InglésEnglish Verbal Proficiency |  | Preferencia ReligiosaReligious Preference |
| **ORIGEN ETNICO** |  *ETHNICITY* |
|  |
|  **¿Es Ud. Español, Hispano o Latino?** Are You Spanish, Hispanic or Latino? | [ ]  Si Yes | [ ]  No No | [ ]  Desconocido Unknown |  |
|  |
|  **Por favor indique hasta dos etnias que mejor lo describan:**“**1**” para Primaria y “**2**” para Secundaria Please Indicate Up to Two Ethnicities That Best Describe You: **“1”** for Primary and **“2”** for Secondary |
|  |
| \_\_\_  | AleutianoAleut | \_\_\_ | Nativo de HawaiiHawaiian Native | \_\_\_  | PakistaníPakistani |
| \_\_\_  | ArgelinoAlgerian | \_\_\_ | Hispano/Otro           Hispanic-Other | \_\_\_  | PalestinoPalestinian |
| \_\_\_  | AmerasiaticoAmerasian | \_\_\_ | Indian (Asiatico)Indian (Asian) | \_\_\_  | PortoriqueñoPuerto Rican |
| \_\_\_  | BangladeshiBangladeshi | \_\_\_ | IraníIranian | \_\_\_  | SamoanoSamoan |
| \_\_\_  | Afro-Americano/NegroBlack / African-American | \_\_\_ | IraquíIraqi | \_\_\_  | SomalíSomalian |
| \_\_\_  | CamboyanoCambodian | \_\_\_ | JaponésJapanese | \_\_\_  | Sur o Centro-AmericanoSouth or Central American |
| \_\_\_  | Caucasico / Europeo / BlancoCaucasian/European/WhiteChino | \_\_\_ | CoreanoKorean | \_\_\_  | EspañolSpanish |
| \_\_\_  | \_\_\_ | LaosianoLaotian | \_\_\_  | CeilanésSrilankan |
| \_\_\_  | ChineseCubano | \_\_\_ | LibanésLebanese | \_\_\_  | TailandésThai |
| \_\_\_  | CubanEgipcio | \_\_\_ | MexicanoMexican | \_\_\_  | VietnamitaVietnamese |
| \_\_\_  | EgyptianEsquimal | \_\_\_ | Indio AmericanoNative American | \_\_\_  | DesconocidoUnknown |
| \_\_\_  | EskimoFilipino | \_\_\_ | Otro Asiático          Other Asian | \_\_\_  | Prefiere No ContestarDecline to State |
| \_\_\_  | FilipinoGuamanian | \_\_\_ | Isleño del PacíficoPacific Islander | \_\_\_  | Otro           Other  |
|  | Guamanian | (pero no Hawaiano / Guames / Samoano)(Not Hawaiian / Guamanian / Samoan) |

|  |  |
| --- | --- |
| **información familiar** | *FAMILY INFORMATION* |
|  |
| **Estado Civil**Client Marital Status |
| [ ]  Soltero Single | [ ]  Casado Married | [ ]  Divorciado Divorced | [ ]  Separado Separated |
| [ ]  Viudo Widowed | [ ]  Pareja de Hecho Domestic Partnership |  |
|  |
| **Para cuántas personas es usted el Cuidador Principal?**For how many people are you the Primary Caregiver? | **Hasta la edad de 17 años** Through Age 17 |
| *Definición del Cuidador Principal: 50% o más de su tiempo* | **18 o mayor** 18 or Older |
|  |
|       |  |       |  |       |
| Apellido de la MadreMother’s Last Name |  | Primer Nombre de la MadreMother’s First Name |  | Segundo Nombre de la MadreMother’s Middle Name |
|  |
|       |  | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Apellido de Soltera de la MadreMother’s Maiden Name |  | Fecha de nacimiento de la madreMother’s Date of Birth |
|  |
|       |  |       |  |       |
| Apellido del padreFather’s Last Name |  | Primer nombre del padreFather’s First Name |  | Segundo Nombre del padreFather’s Middle Name |
|  |
| **INFORMACIÓN DE EMPLEO DEL CLIENTE** | *CLIENT EMPLOYMENT INFORMATION* |
|  |
| **Por favor seleccione la opción que mejor describe su situación de empleo actual:**Please selelct the option that best describes your current employment status |
| [ ]  Competitivo F/T (> 34hrs/wk) Competitive F/T (>34hrs/wk) | [ ]  No-Competitivo F/T (> 34hrs/wk) Non-Competitive F/T (>34hrs/wk) | [ ]  Estudiante Student |
| [ ]  Competitivo P/T (<35hrs/wk) Competitive P/T (<34hrs/wk) | [ ]  No-Competitivo P/T (<35hrs/wk) Non-Competitive P/T (<34hrs/wk) | [ ]  Ama de Casa Homemaker |
| [ ]  Retiredo/a Retired | [ ]  Voluntario/a Volunteer | [ ]  Buscando trabajo Actively Looking | [ ]  Residente/Preso Resident / Inmate | [ ]  Otro  Other |
| ***Definición de Empleo Competitive y No-Competitivo:******Empleo Competitive*** *= Empleo pago en la comunidad, en una posición que está disponible también para personas que no son discapacitadas. Esto podría incluir posiciones que tienen servicios de apoyo en el lugar de trabajo o fuera del mismo (Empleo con Apoyo).****Empleo******No-Competitivo*** *= Trabajos pagos en la comunidad que están disponibles solamente para personas discapacitadas*. |
|  |
|       |  |       |
| OcupaciónOccupation |  | EmpleadorEmployer |
| **INFORMACIÓN ESCOLAR DEL CLIENTE** | *CLIENT SCHOOL INFORMATION* |
|  |
| **Nivel de Educación Cumplido:**Highest Education Completed: |
| [ ]  Jardín de Infantes Kindergarten | [ ]  1er. Grado 1st Grade | [ ]  2do Grado 2nd Grade | [ ]  3er Grado 3rd Grade | [ ]  4° Grado 4th Grade | [ ]  5° Grado 5th Grade |
| [ ]  6° Grado 6th Grade | [ ]  7° Grado 7th Grade | [ ]  8° Grado 8th Grade | [ ]  9° Grado 9th Grade | [ ]  10° Grado 10th Grade | [ ]  11° Grado 11th Grade |
| [ ]  12° Grado (Graduado de HS o GED) 12th Grade (HS Grad or GED) | [ ]  1° Año Univ. 1st Year College | [ ]  Título de AsociadoAssociate Degree |
| [ ]  3° Año Univ. 3rd Year College | [ ]  Licenciatura Bachelor’s Degree | [ ]  1 Año de Graduado 1st Year Grad Work | [ ]  Título de MaestríaMaster’s Degree |
| [ ]  3° Año de Grad. 3rd Year Grad Work | [ ]  Doctorado Doctorate | [ ]  Ninguno None | [ ]  Desconocido Unknown | [ ]  Otro Other |
|  |
|       |  |       |  |       |
| Nombre de la escuela donde asisteName of School Attending |  | Nombre de persona de contacto en la escuelaName of School Contact |  | Número de teléfono de la persona de contactoContact’s Phone Number |
|  |
| **GENERAL MEDICAL CONDITIONS** |  |
|  |
| **Indique cualquier condición médica general:** Usé "**1**" para primaria y "**2**" para secundariaSeleccione una marca de verificación junto a las condiciones médicas generales adiciones,si usted tiene más de dos (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). |
|  \_\_\_\_ | Paciente niega cualquier condición médicaPatient Denies Any Medical Conditions |  \_\_\_\_ | Síndrome del túnel CarpianoCarpal Tunnel Syndrome |
|  \_\_\_\_ | AlergiasAllergies |  \_\_\_\_ | Enfermedad Pulmonar Obstructiva CrónicaChronic Obstructive Pulmonary Disease (COPD) |
|  \_\_\_\_ | AnemiaAnemia |  \_\_\_\_ | CirrosisCirrhosis |
|  \_\_\_\_ | Enfermedad Arterial EscleróticaArterial Sclerotic Disease |  \_\_\_\_ | Trastornos CongénitosCongenital Disorders |
|  \_\_\_\_ | AsmaAsthma |  \_\_\_\_ | Insuficiencia Cardíaca CongestivaCongestive Heart Failure |
|  \_\_\_\_ | Dolor de Espalda/ CuelloBack / Neck Pain |  \_\_\_\_ | Fibrosis QuísticaCystic Fibrosis |
|  \_\_\_\_ | Ciego / Visualmente DiscapacitadoBlind / Visually Impaired |  \_\_\_\_ | Sordo / Discapacidad AuditivaDeaf / Hearing Impaired |
|  \_\_\_\_ | Trastorno Sanguíneo (Aparte de Anemia)Blood Disorder (other than Anemia) |  \_\_\_\_ | DemenciaDementia |
|  \_\_\_\_ | CancerCancer |  \_\_\_\_ | Trastorno Dermatológico / Lesiones de la pielDermatologic Disorder / Skin Lesions |

***Continúa en la página siguiente***

|  |  |  |  |
| --- | --- | --- | --- |
|  \_\_\_\_ | DiabetesDiabetes | \_\_\_\_ | Distrofia MuscularMuscular Dystrophy |
|  \_\_\_\_ | Trastorno DigestivoDigestive Disorder | \_\_\_\_ | Problema Musculoesquelético (No de la espalda / Cuello)Musculoskeletal Problem (not back / neck) |
|  \_\_\_\_ | Infecciones de oídosEar Infections | \_\_\_\_ | Trastorno NeurológicoNeurologic Disorder |
|  \_\_\_\_ | Trastornos EndocrinosEndocrine Disorder | \_\_\_\_ | ObesidadObesity |
|  \_\_\_\_ | Epilepsia / ConvulsionesEpilepsy / Seizures | \_\_\_\_ | OsteoartritisOsteoarthritis |
|  \_\_\_\_ | Problemas de la Vesícula BiliarGall Bladder Problems | \_\_\_\_ | OsteoporosisOsteoporosis |
|  \_\_\_\_ | Trastorno GenitourinarioGenitourinary Disorder | \_\_\_\_ | Dolor (Crónico)Pain (Chronic) |
|  \_\_\_\_ | Enfermedad de Reflujo GastroesofágicoGERD | \_\_\_\_ | Enfermedad de ParkinsonParkinson’s Disease |
|  \_\_\_\_ | Dolores de Cabeza (No migrañas)Headaches (not Migraines) | \_\_\_\_ | Discapacidad FísicaPhysical Disability |
|  \_\_\_\_ | Enfermedad CardíacaHeart Disease | \_\_\_\_ | PsoriasisPsoriasis |
|  \_\_\_\_ | HepatitisHepatitis | \_\_\_\_ | Insuficiencia Renal / EnfermedadRenal Failure / Disease |
|  \_\_\_\_ | HipercolesterolemiaHypercholesterolemia | \_\_\_\_ | Artritis ReumatológicoRheumatologic Arthritis |
|  \_\_\_\_ | HiperlipidemiaHyperlipidemia | \_\_\_\_ | Trastorno ReumatológicoRheumatologic Disorder |
|  \_\_\_\_ | HipertensiónHypertension | \_\_\_\_ | Enfermedad Transmisible Sexualmente (ETS)Sexually Transmitted Disease (STD) |
|  \_\_\_\_ | HipertiroidismoHyperthyroid | \_\_\_\_ | EmbolioStroke |
|  \_\_\_\_ | HiportiroidismoHypothyroid | \_\_\_\_ | TinnitusTinnitus |
|  \_\_\_\_ | Trastorno InmunológicoImmunologic Disorder | \_\_\_\_ | UlcerasUlcers |
|  \_\_\_\_ | InfertilidadInfertility | \_\_\_\_ | Bajo de PesoUnderweight |
|  \_\_\_\_ | MigrañasMigraines | \_\_\_\_ | Otro           Other |
|  \_\_\_\_ | Esclerosis MúltipleMultiple Sclerosis | \_\_\_\_ | Desconocido / No Fue Posible de EvaluarUnknown / Not Able to Assess |

|  |  |
| --- | --- |
| **información de referencia** | *REFERRAL INFORMATION* |
|  |
| Cómo se enteró de nuestros servicios?      How did you find out about our services? |

|  |  |
| --- | --- |
| **contacto para casos de emergencia** | *EMERGENCY CONTACTS* |
| ¿A quién podemos llamar en caso de emergencia? | *Who should we contact in case of an emergency?* |
|  |
| **Primario** – Relación del Cliente con el Contacto:      Primary - Client’s Relationship to Emergency Contact |
|       |  |       |
| Nombre y ApellidoName (Last, First) |  | DirecciónAddress |
|  |
|       |  |    |  |       |
| CiudadCity |  | EstadoState |  | Código PostalZip |
|  |
|       |  |       |  |       |
| Teléfono de CasaHome Phone |  | Teléfono del Trabajo / ExtBusiness Phone / Ext. |  | Teléfono CelularCell Phone |
|  |
| **Secundario** – Relación del cliente con el contacto      Secondary - Client’s Relationship to Emergency Contact |
|       |  |       |
| Nombre y ApellidoName (Last, First) |  | DirecciónAddress |
|  |
|       |  |    |  |       |
| CiudadCity |  | EstadoState |  | Código PostalZip |
|  |
|       |  |       |  |       |
| Teléfono de CasaHome Phone |  | Teléfono del Trabajo / ExtBusiness Phone / Ext. |  | Teléfono CelularCell Phone |

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|  |
|  **información del tutor** | *CONSERVATORSHIP* |
|  |
| ¿Está Ud. bajo Tutoría? [ ]  Si [ ]  No [ ]  DesconocidoAre You on Conservatorship? Yes No Unknown |  |  |
|  |  | Cliente Relación con el TutorClient Relationship to Conservator |
|  |
|       |  |       |  |       |
| Apellido del TutorConservator Last Name |  | Primer Nombre del TutorConservator First Name |  | Segundo Nombre del TutorConservator Middle Name |
|  |
|       |  |       |
| Dirección Postal del Tutor (Calle o Casilla de Correo)Conservator Mailing Address (Street or PO Box) | [ ]  Ap [ ]  Unidad [ ]  N° de Suite Apt Unit Suite # |
|  |
|       |  |    |  |       |
| Ciudad donde vive el TutorConservator Mailing Address City |  | EstadoState |  | Código PostalZip |
|  |
|       |  |       |  |       |
| Teléfono de CasaHome Phone |  | Teléfono CelularCell Phone |  | Teléfono del Trabajo / ExtBusiness Phone / Ext |
|  |
|       |  |       |  |
| Número del Caso JudicialCourt Case Number |  | ¿Es el Tutor PAPG o Privado?Is Conservator PAPG or Private? |  |
|  |

**ALTO**

Las dos últimas páginas son solo para uso clínico.

Por favor, devuelva este paquete al personal de recepción.

|  |
| --- |
| **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**  |

|  |  |
| --- | --- |
| **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:**  |  **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** |