NAMI Southern Santa Barbara County
National Alliance on Mental Illness

Medical/Mental Health Information from Family Member or Other Concerned Party

Name of person completing form:

Signature:

Relationship to consumer/client:

Date:

Consumer/Client Information

Name:

Date of Birth:

Phone:

Address:

Primary Language:

Medi-Cal: ___Yes ___No Medicare: ___Yes ___No
If Yes, Medi-Cal/Medicare number:

Name of Private Medical Insurer:

Current living situation? ___Family ___Independent ___Homeless ___Transitional ___Board & Care/Room and Board ___Supported Housing ___ Other
If other, please describe:

Is the living situation stable? ___Yes ___No

Please ask the client to sign an authorization permitting you to communicate with me about his/her care ___Yes ___ No

I wish to be contacted as soon as possible in case of emergency, transfer and discharge ___Yes ___ No

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Consumer/Client has a Wellness Recovery Action Plan (WRAP) or Advance Directive ___Yes ___No

(If yes, and a copy is available please attach a copy to this form.)

Brief history of mental illness

(Attach additional pages, if necessary).

Age of onset:

Prior 5150's? ___Yes ___No ___Don't know

If yes, when/where:

Prior hospitalizations? ___Yes ___No ___Don't know

If yes, when/where?

Does client have a conservator? ___Yes ___No ___Don't know

If yes, name and phone:

Does the client have a diagnosis? ___Yes ___No ___Don't know

If yes, what?

Please describe any triggers that might disturb the client:

Current Medications / Treatment Professionals

Medication Name(s) and dosage:

Treatments that have helped:

Treatments that did not help:

Significant medical condition(s):

Allergies to medications, food, etc.:

Primary Care Physician:

Phone:

Psychiatrist:

Phone:

Case Manager/Therapist:

Phone: