

(ADULT)

**KERN COUNTY MENTAL HEALTH SYSTEM OF CARE**  
**INFORMATION PROVIDED BY FAMILY MEMBER**

This form is completed by a family member of the individual served (name)\_\_\_\_\_. The form was developed to provide a mechanism to communicate their family member's mental health history pursuant to the provisions of Welfare and Institutions Code 5150.05, which requires mental health staff making decisions about involuntary treatment to consider information supplied by family members.

Name of Individual Served:		
Date of Birth:	Social Security Number:	
Religion ( <i>Optional</i> ):	Language:	
Address:		
	( <i>Street</i> )	( <i>City</i> )
		( <i>State and Zip</i> )
Phone Number:		
Medi-Cal: <input type="checkbox"/> Yes/ <input type="checkbox"/> No	Medi-Cal No:	Medicare: <input type="checkbox"/> Yes/ <input type="checkbox"/> No
Private Medical Insurer (If applicable)		
Please ask my relative to sign an authorization permitting you to communicate with me regarding his/her care: (If a Release of Information is not signed we are not allowed to share confidential information.)		
		<input type="checkbox"/> Yes/ <input type="checkbox"/> No
I wish to be contacted as soon as possible in case of emergency:		
		<input type="checkbox"/> Yes/ <input type="checkbox"/> No
My relative has a Wellness Recovery Plan or Advanced Directive:		
		<input type="checkbox"/> Yes/ <input type="checkbox"/> No
A copy of the Advanced Directive is attached.		
		<input type="checkbox"/> Yes/ <input type="checkbox"/> No
<b>BRIEF HISTORY OF MENTAL ILLNESS</b>		
At what age did mental illness begin?		
What diagnosis was given to this individual?		
Does this individual use drugs? <input type="checkbox"/> Yes/ <input type="checkbox"/> No		
What substances have been taken recently		
<b>Medications:</b> (Use additional pages if necessary)		
Medications individual has taken:		
Medications individual has responded well to:		
Medications which have caused adverse reactions:		
<b>Allergies:</b> (medications, foods, chemical, other)		
<b>Other medical conditions</b> impacting quality of life (e.g. diabetes)		
Treating Physician:	Phone Number:	
Case Manager/Therapist:	Phone Number(s):	
Current Living Situation:		
Information Submitted By: (print name):		
Relationship to Individual Served:		
Address:		
	( <i>Street</i> )	( <i>City</i> )
		( <i>State and Zip</i> )
Phone:		
<b>Signature:</b>		<b>Date:</b>

**CURRENT REASONS FOR CONCERN**  
**(PLEASE CHECK ALL THE BOXES THAT APPLY)**

INDIVIDUAL EXCLUDES FAMILY WHEN DECOMPENSATING	<input type="checkbox"/>
INDIVIDUAL IS NOT TAKING MEDICATIONS	<input type="checkbox"/>
INDIVIDUAL IS DANGER TO SELF/OTHERS	<input type="checkbox"/>
INDIVIDUAL IS UNDER THE INFLUENCE OF ALCOHOL	<input type="checkbox"/>
INDIVIDUAL IS UNDER THE INFLUENCE OF DRUGS	<input type="checkbox"/>
INDIVIDUAL IS NOT ABLE TO PROVIDE OR UTILIZE ASSISTANCE FOR SHELTER	<input type="checkbox"/>
INDIVIDUAL IS NOT ABLE TO PROVIDE OR UTILIZE ASSISTANCE FOR FOOD	<input type="checkbox"/>
INDIVIDUAL IS NOT ABLE TO PROVIDE OR UTILIZE ASSISTANCE FOR CLOTHING	<input type="checkbox"/>
INDIVIDUAL HAS HISTORY OF NOT CONTINUING MENTAL HEALTH TREATMENT	<input type="checkbox"/>
<b>POLICE CALLED?</b>	<input type="checkbox"/>
<b>SHERIFF CALLED?</b>	<input type="checkbox"/>
<b>MET VISIT?</b>	<input type="checkbox"/>
<b>CSU VISIT?</b>	<input type="checkbox"/>

**SUMMARY OF THE RISK**

<b>WHAT IS OCCURING NOW?</b>
<b>WHAT HAS LED TO THIS OVER THE PAST TWO OR THREE WEEKS?</b>
<b>HISTORICALLY, WHAT HAPPENDED IN SIMILAR CIRCUMSTANCES THAT CAUSES CONCERN NOW?</b>
<b>WHAT SPECIFIC TREATMENT ACTION DOES FAMILY REQUEST?</b>
<b>WHAT IS YOUR CONCERN IF TREATMENT IS NOT RECEIVED NOW?</b>