KERN COUNTY MENTAL HEALTH SYSTEM OF CARE (CHILD)

INFORMATION PROVIDED BY FAMILY MEMBER

This form is completed by a family member of the child (name)_____. The form was developed to provide a mechanism to communicate their child'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 Child:		
Date of Birth:	Social Security Number:	
Address:		
(Street)	*(City)*	*(State and Zip)*
Phone Number:		
Medi-Cal: ☐Yes/☐No	Medi-Cal No.:	Medicare: ☐Yes/☐No
Preferred Language:	Religion: (Optional)	
Private Medical Insurer (If applicable)	Medical No.:	
Person(s) with legal custody of child:		
Person(s) with physical custody of child:		
Is the child a ward of the court per Welfare & Institutions Code § 602 (on probation)?		☐Yes/☐No
If "Yes," name of Probation Officer (name):	Phone: ( )	
May Probation Officer be contacted? ☐Yes/☐No	Is Release of Information signed?	☐Yes/☐No
Is the child a ward of the court per Welfare & Institutions Code § 300		☐Yes/☐No
If "Yes," who is child's Social Worker (name):	Phone: ( )	
May Social Worker be contacted? ☐Yes/☐No	Is Release of Information signed?	☐Yes/☐No
If "Yes," who is child's Attorney? (name)	Phone: ( )	
May Attorney be contacted? ☐Yes/☐No	Is Release of Information signed?	☐Yes/☐No
I wish to be contacted as soon as possible in case of emergency:		☐Yes/☐No
I am the child's legal guardian		☐Yes/☐No
Emergency Contact Information (Name):		
Phone Number:		
Relationship to Child:		

THIS DOCUMENT MAY BECOME A LEGAL RECORD WHICH MAY BE MADE AVAILABLE TO THE PATIENT.

BRIEF HISTORY OF MENTAL ILLNESS

AT WHAT AGE DID MENTAL ILLNESS BEGIN?
WHAT DIAGNOSIS WAS GIVEN TO THE CHILD?
DOES THIS CHILD USE DRUGS OR ALCOHOL? ☐YES/☐NO
WHICH SUBSTANCES HAS THE CHILD TAKEN RECENTLY?
NAMES OF MEDICATIONS CHILD HAS TAKEN:
MEDICATIONS CHILD HAS RESPONDED WELL TO:
MEDICATIONS WHICH HAVE CAUSED ADVERSE REACTIONS:
ALLERGIES (MEDICATIONS, FOODS, CHEMICALS, OTHER)
OTHER MEDICAL CONDITIONS INMPAIRING QUALITY OF LIFE (E.G. DIABETES):
TREATING PHYSICIAN: PHONE NUMBER:
CASE MANAGER/THERAPIST PHONE NUMBER (S)
INFORMATION SUBMITTED BY: (IF DIFFERENT FROM EMERGENCY CONTACT):
RELATIONSHIP TO CHILD:
ADDRESS:
(STREET) *(CITY)* *(STATE & ZIP)*
PHONE NUMBER(S):
SIGNATURE: DATE:

THIS DOCUMENT MAY BECOME A LEGAL RECORD WHICH MAY BE MADE AVAILABLE TO THE PATIENT.

CURRENT REASONS FOR CONCERN

(PLEASE CHECK ALL THE BOXES THAT APPLY)

CHILD EXCLUDES FAMILY WHEN DECOMPENSATING	☐
CHILD IS NOT TAKING MEDICATIONS	☐
CHILD IS DANGER TO SELF	☐
CHILD IS DANGER TO OTHERS	☐
CHILD IS UNDER THE INFLUENCE OF ALCOHOL	☐
CHILD IS UNDER THE INFLUENCE OF DRUGS	☐
CHILD IS NOT ABLE TO PROVIDE OR UTILIZE ASSISTANCE FOR SHELTER	☐
CHILD IS NOT ABLE TO PROVIDE OR UTILIZE ASSISTANCE FOR FOOD	☐
CHILD IS NOT ABLE TO PROVIDE OR UTILIZE ASSISTANCE FOR CLOTHING	☐
CHILD HAS HISTORY OF NOT CONTINUING MENTAL HEALTH TREATMENT	☐
POLICE CALLED?	☐
SHERIFF CALLED?	☐
MET VISIT?	☐
CSU VISIT?	☐

SUMMARY OF THE RISK

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

THIS DOCUMENT MAY BECOME A LEGAL RECORD WHICH MAY BE MADE AVAILABLE TO THE PATIENT.