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

Signature: Date:	
(Street) (City) Phone:	(State and Zip)
Address: (Ctroot)	/Ct-t 17' \
Relationship to Individual Served:	
Information Submitted By: (print name):	
Current Living Situation:	
Case Manager/Therapist: Phone Number(s):	STATES THE SE
Treating Physician: Phone Number:	
Other medical conditions impacting quality of life (e.g. diabetes)	a
Other medical conditions imposting quality of life (a.g. disherter)	
Allergies: (medications, foods, chemical, other)	
Medications which have caused adverse reactions:	
Medications individual has responded well to:	
Medications: (Ose additional pages if necessary) Medications individual has taken:	
Medications: (Use additional pages if necessary)	VIII THE TREE TO STATE
What substances have been taken recently	50/140
Does this individual use drugs?	Yes/ No
What diagnosis was given to this individual?	
At what age did mental illness begin?	
At the last of the	
BRIEF HISTORY OF MENTAL ILLNESS	
A copy of the Advanced Directive is attached.	Yes/ No
My relative has a Wellness Recovery Plan or Advanced Directive:	Yes/ No
I wish to be contacted as soon as possible in case of emergency:	Yes/ No
(in a release of information is not signed we are not allowed to share confidential information.)	□Yes/□No
Please ask my relative to sign an authorization permitting you to communicate with me regardi (If a Release of Information is not signed we are not allowed to share confidential information.)	ng his/her care:
Private Medical Insurer (If applicable)	
Medi-Cal: Yes/No Medi-Cal No: Medicare:	☐Yes/☐No
Phone Number:	
(Street) (City)	(State and Zip)
Address:	
Religion (Optional): Language:	
Date of Birth: Social Security Number:	
Name of Individual Served:	
making decisions about involuntary treatment to consider information supplied by family mer	mbers.
pursuant to the provisions of Welfare and Institutions Code 5150.05, which requires mer	ntal health staff
form was developed to provide a mechanism to communicate their family member's menta	l health history
This form is completed by a family member of the individual served (name)	The

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

	AND SECTION OF THE PROPERTY OF	
INDIVIDUAL EXCLUDES	S FAMILY WHEN DECOMPENSATING	
INDIVIDUAL IS NOT TAK	KING MEDICATIONS	
INDIVIDUAL IS DANGER	R TO SELF/OTHERS	
INDIVIDUAL IS UNDER	THE INFLUENCE OF ALCOHOL	
INDIVIDUAL IS UNDER	THE INFLUENCE OF DRUGS	
INDIVIDUAL IS NOT ABL	LE TO PROVIDE OR UTILIZE ASSISTANCE FOR SHELTER	
INDIVIDUAL IS NOT ABL	LE TO PROVIDE OR UTILIZE ASSISTANCE FOR FOOD	
INDIVIDUAL IS NOT ABL	LE TO PROVIDE OR UTILIZE ASSISTANCE FOR CLOTHING	
INDIVIDUAL HAS HISTO	DRY OF NOT CONTINUING MENTAL HEALTH TREATMENT	
POLICE CALLED?	national so	
SHERIFF CALLED?	Good Treat No Medical No New York	
MET VISIT?	released treated to several en	
CSU VISIT?	AN ART TOWN THE SHOULD SEE AN ARM TO DESTRUCT JUST TO SEPTEMBER AND TO SEPTEMBERS AND THE PARTY OF THE PARTY	
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WHAT IS OCCURING N	OW?	
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	BRIEF METORN ROLYSTEM RRISE	-
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WHAT HAS LED TO TH	IIS OVER THE PAST TWO OR THREE WEEKS?	
WHAT HAS LED TO TH	IS OVER THE PAST TWO OR THREE WEERS:	
cyri Pan VIII	Yzpirio nau Indicinos sin s	
	u subabacisa haya neon tuken mewrin	1112
HISTORICALLY, WHAT	HAPPENDED IN SIMILAR CIRCUMSTANCES THAT CAUSES CONCERN NOW?	
	District Designation of the State of the Sta	
	And the second state of the second	1.0
WHAT SPECIFIC TREA	TMENT ACTION DOES FAMILY REQUEST?	
\M=.	and and American Control of the Cont	
WHAT IS YOUR CONCE	ERN IF TREATMENT IS NOT RECEIVED NOW?	
	and Cythig Schwidt as a contract of the contra	
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