



**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
Information from Concerned Party about DMH Client**

**IF THIS IS A PSYCHIATRIC EMERGENCY
PLEASE CALL DMH ACCESS CENTER 1 800-854-7771 OR DIAL 911**

Has the client been informed that the form is being completed? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name of Person Completing the Form:	Date:
Relation to Client:	Phone number:
Name of Client:	Date of Birth:
Provided the proper release has been signed, I wish to be contacted regarding the information on this form. <input type="checkbox"/> YES <input type="checkbox"/> NO	
Please describe specific concern(s) or information you wish to relay to us.	
Do you have additional concern(s) that you wish to relay about any of the following? (Please add additional pages as necessary.)	
<input type="checkbox"/> Living Situation <input type="checkbox"/> Legal Issues <input type="checkbox"/> Diagnosis <input type="checkbox"/> Substance Issues <input type="checkbox"/> Medication(s) <input type="checkbox"/> Medical <input type="checkbox"/> Behavior <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Other:	
If checked, please describe your concern(s).	

I understand that completing this form will help provide information to the members of the client's treatment team. The source of this information may be shared with the client at the discretion of the treatment team.

Signature

Date

**PLEASE FAX THE COMPLETED FORM TO THE DMH - OFFICE OF CONSUMER AND FAMILY AFFAIRS: (213) 252-8767.
IF YOU'RE INTERESTED IN SPEAKING WITH A DMH FAMILY ADVOCATE, PLEASE CALL (213) 738-3948.**