MH 525
Revised 8/13 /18

CONTACT INFORMATION

Client Contacts						
Name	**Relationship to Client***	**Emergency Contact?**	**Telephone Number**	**Address**	**Email**	**Comments**

Relationship to Client:

Mother	Father	Sister	Brother	Grandmother
Foster Mother	Foster Father	Daughter	Son	Grandfather
Legal Guardian	Husband	Wife	Stepdaughter	Stepson
Aunt	Stepmother	Stepfather	Uncle	Other - Specify

Outside Provider Type*/Agency	Outside Provider Name/Title	Medical Record #/Case #	Outside Provider Phone/Address	Outside Provider Email Address

Provider Type:

Primary Care Provider	Probation Officer	Home Health Practitioner	Case Manager	Law Enforcement
Regional Center	School	Therapeutic Behavioral Services	DCFS	Conservator
Other Medical Specialist	Other - Specify	Whole Person Care	Magellan ID	

Name: **ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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