MH 737
2/20/2020

WALK-IN REQUEST FOR SERVICES

LA County DMH provides a spectrum of mental health services to people of all ages who have severe and persistent emotional and/or mental health conditions. Services include:

- ***Mental health services*** *(mental health assessments, individual and group therapy, individual and group rehabilitation)*
- ***Targeted case management Services*** *(assisting with referrals to other services)*
- ***Medication support services*** *(prescribing, administering, & managing effectiveness of psychotropic medications)*
- ***Crisis intervention services*** *(emergency response services)*

I. Request for Mental Health Services

Is this request urgent? ☐ *Yes* ☐ *No*

Reason for request:

_____
_____
_____
_____
_____

II. Information About the Person Who Needs Mental Health Services

Last Name: _____ First Name: _____

Other Names/Alias: _____

Preferred Language: _____ Contact Number: _____

DOB: _____ SSN: _____

Gender: ☐ *Male* ☐ *Female* ☐ *Transgender (F to M)* ☐ *Transgender (M to F)* ☐ *Unknown*

Living Status: ☐ *House or Apartment* ☐ *Foster Family* ☐ *Homeless* ☐ *Board and Care* ☐ *Unknown*

Address: _____

Insurance: ☐ *Indigent* ☐ *Medi-Cal* ☐ *Medicare* ☐ *Medi-Medi* ☐ *Private Insurance* ☐ *Unknown*

Household Income: _____

If the person who needs mental health services is a minor, answer the questions below

Is the parent/legal representative requesting mental health services? ☐ *Yes* ☐ *No*

If no, requester's name and contact information: _____

Parent/Legal Representative Name: _____ Parent/Legal Representative Contact: _____
(if different from above)

Parent/Legal Representative Address (*if different from above*): _____

III. Clinical Information About the Person Who Needs Mental Health Services

Currently receiving outpatient mental health services? ☐ *Yes* ☐ *No* ☐ *Unknown*

If yes, where/from whom? _____

Been on psychotropic medications w/in the past 30 days? ☐ *Yes* ☐ *No* ☐ *Unknown*

Released from jail/juvenile hall/inpatient hospital within the last 7 days? ☐ *Yes* ☐ *No* ☐ *Unknown*

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IV. *Disposition (To be completed by staff)*

☐ *Crisis Referral (this site, 911, FRO)*
☐ *Assessment Appointment Given this Site*
☐ *Referred to System Navigation*
☐ *Referred back to Private Insurance*
☐ *Referred to Another MH Provider*
☐ *Referred to Other Type Agency*
☐ *Other*
☐ *Individual/Collateral Declined Services*
☐ *Unable to Contact Individual/Collateral*
☐ *Already Receiving Appropriate MH Services*
☐ *Untimely Appointment This Site, Referral Declined*

If appointment given:

Appointment Practitioner: _____
Appointment Program: _____
Appointment Date: _____
Appointment Time: _____
Was an earlier appointment offered:
☐ *Yes* ☐ *No*
If yes, date of first offered appointment:
_____

If medication appears to be a need:

☐ *Medication Appointment Given this Site*
☐ *Medication Needs TBD at Initial Assessment*
☐ *Interim Referral for Medication Evaluation*
☐ *Other*

Med Appointment Practitioner:_____

Medication Appointment Program:
_____

Medication Appointment Date: _____
Appointment Time: _____
Was an earlier appointment offered:
☐ *Yes* ☐ *No*
If yes, date of first offered appointment:
_____

Disposition Details:

_____
_____
_____
_____

Comments, Cultural Considerations and/or Special Needs:

_____
_____
_____
_____

_____	_____	_____	_____
Staff Signature*	**Date**	**Co-Signature***	**Date**