MH 725
11/01/2017

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 U NO U	
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. U YES U 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.)

- **U Living Situation**
- **U Legal Issues**
- **U Diagnosis**
- **U Substance Issues**
- **U Medication(s)**
- **U Medical**
- **U Behavior**
- **U Treatment Plan**
- **U 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.