

# DIAGNOSIS INFORMATION

**Type of Diagnosis:**       Admission Diagnosis       Update Diagnosis

**Date of Diagnosis:** \_\_\_\_\_

**Current Diagnosis:**

Primary	ICD-10 Code _____	DSM 5 Description: _____
Secondary	ICD-10 Code _____	DSM 5 Description: _____
Tertiary	ICD-10 Code _____	DSM 5 Description: _____
Tertiary	ICD-10 Code _____	DSM 5 Description: _____
Tertiary	ICD-10 Code _____	DSM 5 Description: _____
Tertiary	ICD-10 Code _____	DSM 5 Description: _____
Tertiary	ICD-10 Code _____	DSM 5 Description: _____
Tertiary	ICD-10 Code _____	DSM 5 Description: _____
Tertiary	ICD-10 Code _____	DSM 5 Description: _____

**Remarks**  
*Indicate documentation that supports diagnosis (e.g. Initial Medication Evaluation, Crisis Intervention Service, Assessment Addendum)*

**CSI:**  
 Trauma:  Yes  No  Unknown  
 Substance Abuse/Dependence:  Yes  No  Unknown / Not reported  
 Substance Abuse/Dependence Diagnosis: \_\_\_\_\_  
 General Medical Condition(s): \_\_\_\_\_

_____	Date	_____	Date
Signature & Discipline		Co-signature & Discipline (when required)	

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: \_\_\_\_\_ DMH ID#: \_\_\_\_\_  
 Agency: \_\_\_\_\_ Provider #: \_\_\_\_\_  
**Los Angeles County – Department of Mental Health**

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