



LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH Community Assistance Recovery and Empowerment (CARE) Referral Form

\*Please note that the CARE Program does not have the authority to mandate medication or involuntary long-term hospitalization and/or LPS Conservatorship.

Please send the completed referral by e-mail: CareCourt@dmh.lacounty.gov

Todays Date: Court Order Date:

Reporting Party Information

Name and Discipline: Relation to candidate: Agency: E-Mail: Phone:

CARE Candidate Information

Conserved: YES NO Reappointment Hearing Date: Date Initially Conserved: DMH IBHIS/ IS#: Last name: First name: Date of birth: Social Security #: Veteran: Yes No Address: Phone:

\*\*If homeless please identify a location where the candidate can be found (e.g.Corner of 6th and Vermont)\*\*

Type of housing: Home Apartment Board and Care Homeless shelter Other: Lives alone: Yes No Lives with others (Describe): Primary Language: Race / Ethnicity: Gender: Height: Weight: Hair color:

Income source

Employment: SSI SSDI GR None Other:

Medical history

Known medical diagnosis/concerns: Medications for medical conditions: Psychotropic medications: Candidate is compliant with medications: Yes No Sometimes: Unknown: Other:

Substance Abuse

Known substances used : Frequency: Name(s) of substance abuse treatment programs candidate attended: Treatment program location: Date(s) of attendance:



**CONFIDENTIAL**

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH  
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**Candidate has a diagnosis of Schizophrenia or another psychotic disorder in the same class as defined by DSM V.**

Primary Dx:

Secondary Dx:

**Candidate has been detained for at least two 14-day involuntary hospitalizations within the past 60 days:**

Date:

Location:

Date:

Location:

**Candidate is not currently stabilized in ongoing voluntary treatment.**

Describe:

**Candidate is in need of a higher level of care than a FSP (Full-Service Partnership) or Outpatient program can provide.**

Describe:

**Candidate's mental health symptoms may cause behavior that interferes substantially with their primary activities of daily living.**

Describe:

**Candidate's mental health symptoms may result in their inability to maintain stable adjustment and independence without treatment and support.**

Describe:

**Candidate is unlikely to survive safely in the community without supervision and their condition is substantially deteriorating.**

Describe:

**Candidate needs services and support to prevent relapse or deterioration that would likely lead to GD, DTS, DTO.**

Describe:

**How will candidate benefit from participation in CARE Court?**

Describe:

**Candidate has an open criminal case?** Yes: No:

**Probation:** Yes: No:

No:

**Parole:** Yes: No:

No:

Describe:

**Candidate has an LPS conservator or is under the supervision of Public Guardian?** Yes:

No:

Name of conservator/public guardian:

Phone: