Placer County Systems of Care

Mental Health Family Information Form (AB1424)
Information Provided by a Family Member or other Support Person – Part A

This form serves to provide a means for family members or support persons to communicate about their relative/loved one's (i.e. the client) mental health history pursuant to AB1424, which requires that all staff making decisions about involuntary treatment consider information supplied by family members. Completed forms may be kept on file with the County Mental Health and/or Mental Health Providers for reference during any crisis encounter.

Please ask the client to sign an authorization permitting Placer County Systems of Care providers to communicate with you about his/her care. Understand that without a current Release of Information, you may not receive acknowledgement that the client is receiving services but any information provided may be taken into consideration when making clinical decisions.

☐ Yes ☐ No Provided that proper release has been signed, I wish to be contacted as soon as possible in case of emergency transfer and discharge.

For Adult Clients Only:

☐ Yes ☐ No The client has a Wellness Recovery Action Plan or an Advanced Directive.
(If yes has been marked and a copy of either form is available, please attach a copy to this form.)

Name of Client: ____________________ Date of Birth: __________ Phone No.: __________

Address: ____________________

Primary Language: ____________________ Religion (optional): ____________________

Medi-Cal: ☐ Yes ☐ No Medi-Care: ☐ Yes ☐ No Name of private Medical Insurer: __________

Client's Strengths

Has a support network: ☐ Yes ☐ No Employer/Volunteer Work/School: ____________________

Has life goals: ____________________

Other: ____________________

Current Living Situation ____________________

Mental Illness History

Does the client have a conservator/Payee? ☐ Yes ☐ No If yes, name: ____________________

Mental health history (diagnosis, if known): ____________________

Age mental health concerns began (if known): ____________________

Do you know of any substance use issues? ____________________

Current Medications (Psychiatric and Medical)

Medications that have been effective for the client: ____________________

Medications that have been problematic for the client: ____________________

Does the client consistently take their prescribed medications? ____________________

Treating Mental Health Providers

Psychiatrist: __________ Agency/Program: __________ Phone No.: __________

Case Worker: __________ Agency/Program: __________ Phone No.: __________

Other services the client is currently receiving: ____________________

Medical History

Current medical issues: ____________________

Allergies (medications/food/chemicals/other) ____________________

Primary Care Physician: ____________________ Phone No.: __________

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Information Provided by a Family Member or other Support Person – Part B

Additional Information (Mental Health and Crisis History)

What has been helpful for the client in the past?

How would we know when the client is doing well?

History of mental health crisis (history of dangerousness to self, grave disability, violence, arrest, etc.)?

Additional information you would like to share about the client:

Information submitted by:

Name: ______________________________ Relationship to client: ______________________
Print

______________________________ Date: ______________
Signature

Address: ____ Phone No.: ______________