Information Provided by Family Member or Other Support Person

AB1424 (2001)

This form was developed jointly by Monterey County Behavioral Health, NAMI Monterey County, and mental health persons in care to provide a means for family members and other support people to communicate about the person in care's mental health history pursuant to Welfare and Institutions Code (W & I) Section5008.2, 5150.05, and 5328. Sec. 5150.05 states that "any person who is authorized to take that person, or cause that person to be **taken, into custody pursuant to that section SHALL consider available relevant information about the historical course of the person's mental disorder... "** Mental health staff will place this form in the person in care's mental health chart. Under California and Federal law, persons in care have the right to view their chart. For the purpose of this document, the term "person in care" indicates the individual who is receiving specialty mental health services.

Name of person in care ____

Date of birth ______________________________**Phone**__________________________________

Address ____

Primary language _________________________**Religion** (Optional) ________________________

Medi-Cal? ☐Yes ☐No Medicare? ☐Yes ☐No

Name of private medical insurance____

☐ Yes ☐No Please ask the person in care to sign an authorization permitting their provider(s) to communicate with me about their care.

☐ Yes ☐No I wish to be contacted as soon as possible in case of emergency, transfer, and discharge.

☐ Yes ☐No The person in care has a Wellness Recovery Plan or Advance Directive. (If yes, and a copy is available, please attach a copy to this form)

<u>Brief history of mental illness</u> (age of onset, previous capabilities, and interests, dangerous to self or others, grave disabilities)
Use additional pages if necessary.

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<u>What is the primary concern/challenge/issue the person in care is struggling with right now?</u>
Use additional pages if necessary.

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Does the person in care have a conservator? ☐Yes ☐No

If yes, name of conservator ______________________________

Phone number of Conservator ______________________________

Does the person in care have a Power of Attorney? ☐Yes ☐No

If yes, name of Power of Attorney ______________________________

Phone number of Power of Attorney ______________________________

Do you know person in care's diagnosis? ☐Yes ☐No

If yes, diagnosis ______________________________

Person in care's strengths: ☐Education ☐Employment/Volunteer ☐Goals

☐ Other ______________________________

<u>Current medications</u> (psychiatric and medical)

Name(s): ______________________________

____

Medications the person in care has responded well to: ______________________________

____

Medications that did not work for the person in care: ______________________________

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<u>Treating Psychiatrist and Care Coordinator</u>

Psychiatrist name ______________________ Phone ______________

Care coordinator name ______________________ Phone ______________

<u>Medical</u>

Significant medical conditions ______________________________

Allergies to medications, food, chemicals, other ______________________________

Primary Care Physician ______________________ Phone ______________

<u>Current Living Situation</u>

☐ Family ☐ Independent ☐ Other: ______________

☐ Homeless ☐ Transitional

☐ Board and Care ☐ Supported Independent Living

History of Decompensation

Please check off symptoms or behaviors that the person in care has had in past when decompensating and indicate which ones you are observing with the person in care now.

Symptom or Behavior	Past	Now
Suicide gesture/attempts		
Suicidal statements		
Thinking about suicide		
Cutting on self		
Harming self		
Sleeping too much		
Not sleeping		
Not eating		
Suspicious (paranoia)		
Fire setting		
Aggressive behavior (fighting)		
Threats		
Irrational thought patterns (not making sense)		
Destruction of property		
Sexual harassing/preoccupation		
Hearing voices		
Lack of motivation		
Anxious and fearful		
Avoiding others or isolating		
Talking too much or too fast		
Argumentative		
Other (specify)		

Symptom or Behavior	Past	Now
Weepiness		
Being too quiet		
Expressing feelings of worthlessness		
Afraid to leave the house		
Giving away belongings		
Increased irritability and/or negativity		
Laughing inappropriately		
Stopping medication		
Repetitive behaviors		
Forgetfulness		
Not paying bills		
Taking more medication than prescribed		
Failing to go to doctor's appointments		
Spending too much money		
Poor hygiene		
Overeating		
Impulsive behavior		
Not answering phone/turning off answering machine or voicemail		
Talking to self		
Substance abuse		
Homelessness or running away		
Other (specify)		

History of Crisis Episodes

Date	Crisis Behavior/ Event (Include a description of the crisis and any triggers or precipitants)	Action taken	Results of the action

(Attach additional pages as necessary, see end of document)

What helped the person in care in the past to deal with these crises?______________________________

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What has not been helpful? ____

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Information submitted by

Name (print) ______________________________ Relationship to person in care ____________________

Address ________________________________ Phone ______________________________
(city) (state) (zip)

Signature ______________________________ **Date** ________________
A person "shall be liable in a civil action for intentionally giving any statement that he or she knows to be false" {Welfare & Institutions Code, Section 5150.05(c)}.

History of Crisis Episodes (extra page)

Date	Crisis Behavior/ Event (Include a description of the crisis and any triggers or precipitants)	Action taken	Results of the action