

ATTN: SAN DIEGO DEAF MENTAL HEALTH SERVICESPlease FAX to 619-533-6007 REFERRAL DATE:

CLIENT DATA				DATE OPEN:			
LAST NAME:							
FIRST NAME:						MIDDLE NAME:	
Email /Phone/ Walk-in ?							
Service Requested:							
S/S #		FOSTER /RESIDENTIAL CARE?					
GENDER:		*DOB:		*AGE:			
ENGLISH:		YES NO		*PRIMARY LANGUAGE:		*PREFERRED LANG:	
Marital Status:		DEAF/HOH/DIS?		Crisis or Routine?			
ETHNICITY:		*INSURANCE/MEDICAL#:					
EDUCATION LEVEL:		Employment Status and Position:					
Conservatorship ?:		EMPLOYER:					
CLIENT ADDRESS							
HOMELESS?:		TIME HOMELESS:					
ADDRESS:							
SECOND ADDRESS LINE:							
CITY:		STATE:		*ZIP:		COUNTY:	
*HOME PHONE:		Business Phone:					
*EMAIL ADDRESS:							
EMERGENCY CONTACT							
NAME		RELATIONSHIP		PHONE		EMAIL	
SDDMHS STAFF taking the information:							
NAME:		DATE:					
MENTAL HEALTH HISTORY & CLIENT'S SIGNATURE							
Mental Health Issue :							
Referral Source Name:		Substance Abuse?					
Referral Source Phone and Email:		Legal Issues?					
*CLIENT SIGNATURE							
RELEASE THIS FORM							