APPLICATION FOR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT

Confidential Client/Patient Information

See California W&I Code Section 5328 and HIPAA Privacy Rule

45 C.F.R. § 164.508

Welfare and Institutions Code (W&I Code), Section 5150(f) and (g), require that each person, when first detained for psychiatric evaluation, be given certain specific information orally and a record be kept of the advisement by the evaluating facility.

☐ **Advisement Complete** ☐ **Advisement Incomplete**

Good Cause for Incomplete Advisement:

DETAINMENT ADVISEMENT

My name is _____
I am a (~~peace officer~~/mental health professional) with L.A. Downtown Medical Center.
You are not under criminal arrest, but I am taking you for examination by mental health professionals at L.A. Downtown Medical Center .

You will be told your rights by the mental health staff.

If taken into custody at his or her residence, the person shall also be told the following information:

You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

Advisement Completed By:	Position:	Language or Modality Used:	Date of Advisement:

To (name of 5150 designated facility): L.A. Downtown Medical Center ☐1711 W. Temple St., Los Angeles, CA 90026 ☐7500 Hellman Ave., Rosemead, CA 91770
Application is hereby made for the assessment and evaluation of _____ D.O.B. _____
residing at _____, California, for up to 72- hour assessment, evaluation and crisis intervention or placement for evaluation and treatment at a designated facility pursuant to Section 5150, et seq. (adult) or Section 5585 et seq. (minor), of the W&I Code. If a minor, authorization for voluntary treatment is not available and to the best of my knowledge, the legally responsible party appears to be / is: (**Check one**): ☐ ***Parent***; ☐ ***Legal Guardian***; ☐ ***Conservator***; ☐ ***Juvenile Court under W&I Code 300***; ☐ ***Juvenile Court under W&I Code 601/602.***

If known, provide names, address and telephone numbers in area provided below:
The above person's condition was called to my attention under the following circumstances:

I have probable cause to believe that the person is, as a result of a mental health disorder, a danger to others, or to himself/ herself, or gravely disabled because: (state specific facts):

(CONTINUED ON NEXT PAGE)

CLIENT NAME: _____

APPLICATION FOR 72 HOUR DETENTION FOR EVALUATION AND TREATMENT (CONTINUED)

Historical course of the person's mental disorder:

☐ I have considered the historical course of the person's mental disorder: [Includes evidence presented by service/support provider, family member(s), and person subject to probable cause determination or designee.]

☐ No reasonable bearing on determination

☐ No information available **because**:

History Provided by (Name)	Address	Phone Number	Relation
			Self

Based upon the above information, there is probable cause to believe that said person is, as a result of mental health disorder:

☐ **A danger to himself / herself** ☐ **Gravely disabled adult**

☐ **A danger to others** ☐ **Gravely disabled minor**

Minors only: ☐ Based upon the above information, it appears that there is probable cause to believe that authorization for voluntary treatment is not available.

*Signature, title **and** badge number* of peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, designated members of a mobile crisis team, or professional person designated by the county.

X_____Badge/NPI#_____	Date: Time:	Phone: (213) 989-6100

Name of Law Enforcement Agency or Evaluation Facility/Person:	**Address of Law Enforcement Agency or Evaluation Facility/Person:**	For patients in Medical ERs, detention began:
L.A. Downtown Medical Center	1711 West Temple Street Los Angeles, CA 90026	Date: Time:

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

Notify (officer/unit & telephone #): _____

NOTIFICATION OF PERSON'S RELEASE IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

☐ The person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.

☐ Weapon was confiscated pursuant to Section 8102 W&I Code. Upon release, facility is required to provide notice to the person regarding the procedure to obtain return of any confiscated firearm pursuant to Section 8102 W&I Code.

SEE SUBSEQUENT PAGES FOR DEFINITIONS AND REFERENCES

DEFINITIONS AND REFERENCES

"Gravely Disabled" means a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing and shelter. *SECTION 5008(h) W&I Code*

"Gravely Disabled Minor" means a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. *SECTION 5585.25 W&I Code*

"Peace officer" means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer Standards and Training, or any parole officer or probation officer specified in Section 830.5 of the Penal Code when acting in relation to cases for which he or she has a legally mandated responsibility. *SECTION 5008(i) W&I Code*

Section 5152.1 W&I Code: The professional person in charge of the facility providing 72-hour evaluation and treatment, or his or her designee, shall notify the county mental health director or the director's designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72- hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention if all of the conditions apply:

(a) The peace officer requests such notification at the time he or she makes the application and the peace officer certifies at that time in writing that the person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.
(b) The notice is limited to the person's name, address, date of admission for 72-hour evaluation and treatment, and date of release.

If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information obtained pursuant to the notification requirements of this section, the officer, agency, or designee shall destroy that record two years after receipt of notification.

Section 5150.05 W&I Code:

(a) When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, 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 if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder.
(b) For purposes of this section, "information about the historical course of the person's mental disorder" includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by the person subject to a determination described in subdivision (a) or anyone designated by that person.

DEFINITIONS AND REFERENCES (CONTINUED)

(c) If the probable cause in subdivision (a) is based on the statement of a person other than the one authorized to take the person into custody pursuant to Section 5150, a member of the attending staff, or a professional person, the person making the statement shall be liable in a civil action for intentionally giving any statement that he or she knows to be false.
(d) This section shall not be applied to limit the application of Section 5328.

Section 5152.2 W&I Code: Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officer pursuant to Section 5152.1 W&I Code.

Section 5585.50 W&I Code: The facility shall make every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained. *Section 5585.50 W&I Code.*

A minor under the jurisdiction of the Juvenile Court under Section 300 W&I Code is due to abuse, neglect, or exploitation.

A minor under the jurisdiction of the Juvenile Court under Section 601 W&I Code is due to being adjudged a ward of the court as a result of being out of parental control.

A minor under the jurisdiction of the Juvenile Court under Section 602 W&I Code is due to being adjudged a ward of the court because of crimes committed.

Section 8102 W&I Code (EXCERPTS FROM):

(a) Whenever a person who has been detained or apprehended for examination of his or her mental condition or who is a person described in Section 8100 or 8103, is found to own, have in his or her possession or under his or her control, any firearm whatsoever, or any other deadly weapon, the firearm or other deadly weapon shall be confiscated by any law enforcement agency or peace officer, who shall retain custody of the firearm or other deadly weapon. “Deadly weapon,” as used in this section, has the meaning prescribed by Section 8100.
(b) (1) Upon confiscation of any firearm or other deadly weapon from a person who has been detained or apprehended for examination of his or her mental condition, the peace officer or law enforcement agency shall issue a receipt describing the deadly weapon or any firearm and listing any serial number or other identification on the firearm and shall notify the person of the procedure for the return, sale, transfer, or destruction of any firearm or other deadly weapon which has been confiscated. A peace officer or law enforcement agency that provides the receipt and notification described in Section 33800 of the Penal Code satisfies the receipt and notice requirements.
(2) If the person is released, the professional person in charge of the facility, or his or her designee, shall notify the person of the procedure for the return of any firearm or other deadly weapon which may have been confiscated.
(3) Health facility personnel shall notify the confiscating law enforcement agency upon release of the detained person, and shall make a notation to the effect that the facility provided the required notice to the person regarding the procedure to obtain return of any confiscated firearm.

Health and Safety Code 1799.111 (d):

A person detained under this section in a medical emergency room shall be credited for the time detained, up to twenty-four hours, in the event he or she is placed on a 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code

LADMC LA DOWNTOWN MEDICAL CENTER LLC

Date: _____ Pt. Last Name: _____ Pt. First Name: _____

TREATMENT PLAN RECOMMENDATION

Upon initial evaluation, it is my determination that that patient might benefit from the following treatment plan recommended interventions.		
PROBLEM	**RECOMMENDED INTERVENTIONS**	**TARGET DATE**
☐**DANGER TO SELF**	☐Encourage medication compliance. ☐Encourage verbalization of thoughts and feelings. ☐Educate on de-escalation and coping skills. ☐Encourage participation in treatments groups. ☐Other:	
☐**DANGER TO OTHERS**	☐Encourage medication compliance. ☐Encourage verbalization of thoughts and feelings. ☐Educate on de-escalation and coping skills. ☐Encourage participation in treatments groups. ☐Other:	
☐**GRAVE DISABILITY**	☐Encourage medication compliance. ☐Encourage verbalization of thoughts and feelings. ☐Educate on de-escalation and coping skills. ☐Encourage participation in treatments groups. ☐Other:	

SIGNATURE OF PSYCHIATRIC EVALUATION TEAM CLINICIAN:	**DATE**

CRISIS CLINICIAN TREATMENT RECOMMENDATIONS

Psychiatric Evaluation Team Assessment Form

Date: _____ Site: _____ Referred By: _____

Time Received Call (military): _____ **Time Arrived** (military): _____

Time Assessment Completed (military): _____ **Time of Departure** (military): _____

Client Information

Last Name: _____ First Name: _____ Middle Name: _____

Age: _____ D.O.B.: _____ Sex: ☐**M** ☐**F** S.S.N.: _____ Ethnic Origin: _____

Street Address: _____ City: _____ ZIP Code: _____

Telephone: _____ Marital Status: _____ Occupation: _____

Presenting Problems:

Behaviors: ☐**Aggressive** ☐**Avoidant** ☐**Dependent** ☐**Self-Destructive** ☐**Uncooperative**

Impairments: ☐**Greater Than Six Months** ☐**Less Than Six Months** ☐**Educational** ☐**Social** ☐**Self-Care** ☐**Vocational**

Impaired A.D.L.: ☐**Clothing** ☐**Food** ☐**Hygiene** ☐**Medication** ☐**Money Management** ☐**Shelter** ☐**Transportation**

Name of Conservator: _____ Telephone Number: _____ Power 7: ☐Yes ☐No

Medical Conditions/Problems/History: _____

Developmental Delay: ☐No ☐Yes – ☐Mild ☐Moderate ☐Severe **Regional Center Client:** ☐No ☐Yes – Location: _____

Allergies: ☐No ☐Unknown ☐Yes – Type: _____

Height: _____ Weight: _____ Current Vital Signs – Time: _____ T: _____ P: _____ R: _____ B/P: _____

Pain Scale 0 – 10: _____ Pain Location: _____ Type of Pain: _____ Duration: _____

Current Treatment for Pain: _____

Current Medications (Dosage, Frequency, Last Taken if known): _____

Psychiatric Evaluation Team Assessment Form

Previous Psychiatric Hospitalization(s): ☐No ☐Yes **Number of Previous Admissions:** ____ **Date of Last Admission:** _____

Current Outpatient Treating Psychiatrist: _____ **Telephone Number:** _____

Outpatient/Support Treatment: _____ **Telephone Number:** _____

Relevant Family History: _____

Orientation: ☐All Spheres ☐Person ☐Place ☐Time ☐Situation

Memory Deficit: ☐None ☐All Spheres ☐Short Term ☐Long Term

Concentration: ☐Normal ☐Mild Impairment ☐Moderate Impairment ☐Severe Impairment

Speech: ☐Normal ☐Pressured ☐Slow ☐Rapid ☐Loud ☐Monotone ☐Garbled

Thought Process: ☐Coherent ☐Loose ☐Tangential ☐Perseverative ☐Flight of Ideas

Mood: ☐Euthymic ☐Depressed ☐Anxious ☐Angry ☐Agitated

Affect: ☐Congruent ☐Angry ☐Elated ☐Labile ☐Blunt

Hallucinations: ☐None ☐Auditory ☐Visual ☐Tactile ☐Olfactory ☐Gustatory

D.T.S.: ☐Suicidal Ideation ☐Suicide Attempt ☐Suicide Plan ☐Immediate Self-Endangerment Behavior: _____

D.T.O.: ☐Homicidal Ideation ☐Homicidal Plan ☐Violent Behavior: _____

G.D.: ☐Unable to identify items that will meet nutritional needs. ☐Cannot distinguish shelter from non-shelter.
☐Unable to protectively dress self.

Can client return to current living situation? ☐Yes ☐No **Contact Person:** _____

5150: ☐Yes (☐D.T.O. ☐D.T.S. ☐G.D.) **Refused Voluntary Admission:** ☐Yes ☐No

Disposition: L.A.D.M.C. Urgent Care for Medical Clearance **Inpatient Psych Dr./Internist:** _____

☐**Outpatient Referral:** _____

_____

Provisional Admitting Diagnosis: _____ **Strengths:** _____

INITIAL TREATMENT PLAN	
PROBLEM IDENTIFICATION	**GOALS**
☐Medication Non-Compliance ☐Medication Ineffective	☐Is Medication Complaint ☐Stabilized on Medication
☐Depressed with Suicidal Ideation (S/I) ☐Aggressive Behavior	☐Absence of Suicidal Ideation ☐Absence of Aggressive Behavior
☐Altered Thought Process	☐Decrease Hallucinations/Delusions/Paranoia
☐Self-Care Deficit	☐Explore/Support Helplessness/Dependent Behaviors
☐Other:	☐Other:

Patient Choice Referrals 1.: _____ **2.:** _____ **3.:** _____

Medicare #: _____ **Medi-Cal#:** _____

Other: _____

Signature: _____ **Date/Time:** ____/____

LADMC LA DOWNTOWN MEDICAL CENTER LLC

INGLESIDE CAMPUS
7500 HELLMAN AVE.
ROSEMEAD, CA 91770
(626) 288-1160

DOWNTOWN CAMPUS
1711 W. TEMPLE ST.
LOS ANGELES, CA 90026
(213) 989-6100

Request for Voluntary Admission and Authorization for Treatment

- The undersigned hereby requests admission to L.A. Downtown Medical Center (hereby known as "the Hospital") and consents to such care as is ordered by the undersigned's attending physician of his/her/their associates.
- If my request is granted, I agree to conform to all the rules and regulations of the Hospital. If I wish to leave the Hospital, I will give notice of my desire to leave to a Hospital staff member and will complete all normal departure procedures. If I leave the Hospital against medical advice (A.M.A.), I may choose to leave, and not wait until a responsible relative/friend call for me. I understand that the Hospital will inventory my belongings, in my presence, upon admission and remove (to a secured place) any items which it considers dangerous to my safety and welfare or to the safety and welfare of other patients or Hospital employees.
- I understand that it may be the desire of my attending physician to permit the maximum amount of freedom of action commensurate with my condition as an importation factor in my treatment program. This freedom of action may lead to possible self-injury and I release the Hospital, Hospital employees and agents, as well as my attending physician or his/her/their associates, from all responsibility in case such freedom leads to injury, except where the injury was the employees and agents, or my attending physician or his/her/their agents.

_____ _____ _____ AM/PM

Signature of Patient Date Time

_____

Signature of Other Person Responsible

_____ _____ _____ AM/PM

Signature of Witness Date Time

CERTIFICATE OF ATTENDING PHYSICIAN

I hereby certify that I am the attending physician of the above-named patient, that I have examined the patient with reference to mental condition and based on that examination, it is my opinion that the patient understands the nature of admission to L.A. Downtown Medical Center and the care and treatment to be rendered, and that the patient was mentally competent at the time of the examination to make this application for admission. This certification does not represent a warranty to L.A. Downtown Medical Center.

Additional Comments: _____

_____ _____ _____ AM/PM

Signature of Physician Date Time

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PSYCHIATRIC EVALUATION TEAM ASSESSMENT FORM

Psychiatric Evaluation Team Note

Client Name: ____ Date of Birth: ____________________

Facility Name: _____________________________________ Social Security Number: ____________________

Date of evaluation: ____________________ Time of evaluation: ____________________

Presenting Problems

Evaluation Findings

,