I. PURPOSE

To establish a consistent procedure for the completion of the Initial Contact Form for each person referred to the outpatient and/or case management clinics.

II. PROCEDURE

A. Clerical staff are to complete the first part of the Initial Contact Form (see Attachment 1) on every telephone or walk-in referral.

B. After obtaining this basic information, the clerk is to complete the “DBH Office Use Only” section.

C. If the referred individual is given an appointment for the group screening or intake, clerical staff are to indicate the date and time.

D. If the referred individual is directed elsewhere (another clinic or agency), clerical staff are to indicate where.

E. The second part of the Initial Contact Form may be completed on the telephone by clerical staff or given to the client for completion at the time of screening.

F. After the data on the Initial Contact Form is entered into DBH’s computer system (SIMON), Clerical staff are to maintain the completed form in a file located in the clerical area for six months.
DEPARTMENT OF BEHAVIORAL HEALTH INITIAL CONTACT FORM

Reporting Unit #: ___________________________ Chart #: ___________________________

Last Name   First Name   MI   Gen.   (Alias/Maiden) Last Name   First Name   MI
Street Address
Home Phone ( )
City       State       Zip Code
Work Phone ( )

Type of Service Requested: _______________________________________________________

Date of Birth: __________________    Age: ______    Sex: M F O U    Social Security #: __________

If minor, Name of parent/guardian: __________________________    Relationship: __________________________

Conservatorship: □ Yes □ No    If Yes, indicate Name: __________________________

Medical Insurance Coverage:
□ Medi-Cal Number: __________________________ County: __________________________
□ Medicare □ Blue Cross □ Kaiser □ None □ Other: __________________________

Education: __________________________    Physical Disability: __________________________    Language: __________________________
00 None    00 None    A-English    H-Cambodian    O-Lacano    V-Russian    3-Other Sign
1-20 Grade Levels
01 Severe Visual Impairment    02 Severe Hearing Impairment
Indicate highest grade completed, if higher than 20, use 20
04 Speech Impairment
08 Physical Impairment/Mobility
02 Developmentally Disabled
16 Other Physical Impairment

Ethnicity: __________________________    2nd
A-White    G-Chinese    N-Other Non-White
B-Black    H-Vietnamese    O-Unknown
C-Native American
D-Mex American/ Chicano
E-Latin American
F-Other Spanish

Marital Status: __________________________    Presenting Problem: __________________________
1-White
1-2 Hawaiian Native
2-Other Non-White
B-Black
2-Married/Live together
C-Native American
3-Widowed
D-Mex American/ Chicano
4-Divorced/Dissolved
E-Latin American
5-Separated
F-Other Spanish
6-Unknown

Program Code: __________________________ (Enter 2 if AB2726, 4 if CARS)    Mother's First Name: __________________________

Client Birth Name: __________________________    Birthplace: __________________________

Significant Other Name __________________________    Relationship: __________________________    Phone: __________________________

Significant Other Address: __________________________

Referral Source: __________________________ (Put in Code#)    Employment: __________________________
□ CPS/DCS □ Friend/Family □ MHS
□ Probation/Parole □ Self □ Medical/Legal
□ Other
1- Full Time
2- Part Time
3- Homemaker
4- School
12- Unemployed (looking)
13- Unemployed (Not looking)
15- Not in labor force
16- Unknown

FOR DBH USE ONLY

1. Referred to Screening: □ Yes □ No    Day: __________________________    Date: __________________________
2. Referred to Clinician: □ Yes □ No    Day: __________________________    Date: __________________________
3. Referred elsewhere: □ Yes □ No    Where: __________________________

Form Completed by: __________________________    Date: __________________________    Data Entry Initials: __________________________