COUNTY OF SAN BERNARDINO STANDARD PRACTICE	NO 9-1.13	ISSUE 03/99 PAGE 1 OF 1
	BY Michele DeCourten, LCSW	EFFECTIVE 9/96
DEPARTMENT BEHAVIORAL HEALTH	APPROVED Dick Dwyer Dick Dwyer, Assistant Director	
SUBJECT INITIAL CONTACT FORM		

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.

ocwaitinglist/9/16/98

DEPARTMENT OF BEHAVIORAL HEALTH INITIAL CONTACT FORM

Reporting Unit #:_____ **Chart #:**_____

Last Name	First Name	MI	Gen.	(Alias/Maiden) Last Name	First Name	M.I

Street Address	City	State	Zip Code
Home Phone ( )	Work Phone: ( )		

Type of Service Requested:_____

Date of Birth:_____ Age:____ Sex: M F O or 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:_____

Client or Clerk can fill out

Education:_____

00 None
1-20 Grade Levels
Indicate highest grade completed, if higher than 20, use 20

Physical Disability:_____

00 None
01 Severe Visual Impairment
02 Severe Hearing Impairment
04 Speech Impairment
08 Physical Impairment/Mobility
16 Developmentally Disabled
32 Other Physical Impairment
99 Unknown

Language:_____

A-English, B-Spanish, C-Chinese Dialect, D-Japanese, E-Filipino Dialect, F-Vietnamese, G-Laotian, H-Cambodian, I-Sign Language, J-Other, K-Cantonese, L-Korean, M-Mandarin, N-Armenia, O-Llacano, P-Mien, Q-Hmong, R-Turkish, S-Hebrew, T-French, U-Polish, V-Russian, W-Portuguese, X-Italian, Y-Arabic, Z-Samoan, 1-Thai, 2-Farsi, 3-Other Sign, 4-Other Chinese, 9-Unknown

Ethnicity:_____ 2nd _____

A-White, B-Black, C-Native American, D-Mex American/ Chicano, E-Latin American, F-Other Spanish, G-Chinese, H-Vietnamese, I-Laotian, J-Cambodian, K-Japanese, L-Filipino, M-OtherAsian, N-Other Non-White, O-Unknown, P-Other South East Asian, Q-Korean, R-Samoan, S-Asian Indian, T-Hawaiian Native, U-Guamanian, V-Amerasian, X-Multiple (Only on 2nd one)

Marital Status:____

1 Never Married
2 Married/Live together
3 Widowed
4 Divorced/Dissolved
5 Separated
9 Unknown

Presenting Problem:___

0 None
1 Substance Abuse
2 DD
3 Substance Abuse&DD
4 Physical Health
5 SubAbuse&Physical Health
6 DD & Physical Health
7 SubAbuse,DD,&PhyHE

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

Client Birth Name: _____ (Last, First, MI, Gen) Birthplace: _____ (County, State, Country)

Significant Other Name _____ Relationship:_____ Phone:_____

Significant Other Address:_____

Referral Source:_____ (Put in Code#)
❑ CPS/DCS ❑Friend/Family ❑MHS
❑ Probation/Parole ❑ Self ❑ Medical/Legal
❑ Other _____

Employment:_____
1 Full Time 2 Part Time 4 Homemaker 8 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:_____