If available, this document should accompany the 5150 to the receiving facility.

FAMILY/CAREGIVER INFORMATION FORM

Present this form to any Peace Officer, Psychiatric Emergency Team staff member, or an evaluator performing a 5150 assessment of your family member to determine if he or she meets criteria for a 72-hour evaluation in a psychiatric facility

Name of Individual:			Date of Birth:
Address:			Phone Number:
Current living situation:			
EHR#			
Booking # (Inmates only)			
Primary Language:			
INSURANCE INFORMATION			
Medi-Cal #		Medicare#	
Private Insurance #			
RELEASE OF INFORMATION REQUEST			
Please ask the person being assessed to sign an authorization permitting the hospital to communicate with me regarding his or her care. (I understand that is a Release of Information is not signed, the hospital is not allowed to share confidential information.) Yes ☐ No ☐			
BRIEF HISTORY OF MENTAL ILLNESS			
At what age did the mental illness begin?			
What diagnosis was given?			
What substances, if any, does individual use?			
What substances, if any, have recently been taken?			
Prior hospitalizations / 5150's? When?			
MEDICATIONS			
Medication individual has taken:			
Medications individual has responded well to:			

If available, this document should accompany the 5150 to the receiving facility.

Medication that have caused adverse reactions:			
Allergies (medications, foods, chemical, and other):			
SPECIAL CONSIDERATIONS			
Spiritual/Cultural Needs:			
Dietary Needs:			
PROVIDER INFORMATION			
Outpatient Treatment Team:		Phone:	
Address:			
Case manager/Therapist:		Phone:	
Treating Physician:		Phone	
Address:			
Pharmacy:		Phone:	
Address:			
CONTACT INFORMATION			
Information Submitted by:			
Relationship to individual:			
Address:			
Phone:			
CURRENT REASONS FOR CONCERN (check all that apply)			
		YES	NO
Individual includes family when receiving treatment?		☐	☐
Is individual taking medications?		☐	☐
When were medications last taken?			
Is individual under the influence of alcohol?		☐	☐
Is individual under the influence of drugs/alcohol?		☐	☐
Is individual a danger to self/others?		☐	☐
If yes, please explain:			
Is individual able to provide their own food, clothing, shelter?		☐	☐
Does individual have a history of not continuing mental health treatment?		☐	☐
Law Enforcement called?		☐	☐
Mobile Evaluation Team called?		☐	☐

If available, this document should accompany the 5150 to the receiving facility.

SUMMARY OF THE RISK
What is occurring now?
What has led to this over the past two or three weeks?
Historically, what happened in similar circumstances that causes concern now?
What specific treatment does the family request?
What is your concern if treatment is not received now?

Submitting this form does not guarantee that you will receive information in return unless consent is provided by your family member.

This document may become a legal record, which may be made available to the patient.