Community Partners & Support Services FACE SHEET

ADMISSION/EMERGENCY

Client Full Name: Admissions Date:

Insurance/Name/Number: Client ID#:

Current Address:

DOB: SS#: PHONE: ( )M ( )F

Married ( ) Single ( ) Divorced ( ) Separated ( ) Children ( ) Yes ( ) No
Son ___ Daughter ___

( ) Caucasian ( ) Hispanic ( )Black/African American ( ) Asian ( ) Mixed Race ( ) Other

Parent- Mother Legal Guardian Name:

Married ( ) Single ( ) Divorced ( ) Address: ________________________________
____

Home/Work/Cell #: _________________________ SS#: ____________________________

Parent- Father Legal Guardian Name:

Married ( ) Single ( ) Divorced ( ) Address: ________________________________
____

Home/Work/Cell #: _________________________ SS#: ____________________________

Stepmother's Name: ____

Stepfather's Name: ____

SIBLINGS:

Name **Age** **Sex** **Address**

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IN CASE OF EMERGENCY CONTACT:

Emergency Contact Name/Address: ____
____

Phone:______________________________ Relationship to Client: ______________________

Medical Information

Physicians Name and Telephone:

Psychiatrist Name and Telephone:

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Current Medications:

MEDICAL

PSYCHOTROPIC

Substance Abuse:

Medical problems: Allergies:

Sensory Problems:

Ambulatory Problems:

Advanced Medical Directive <u>Notification</u>

Does client have an advanced medical directive, such as a Do Not Resuscitate (DNR) order, etc.?
( ) Yes ( ) No; If yes, explain

Permission to Treat and/ or Transport in Case of Medical Emergency: ( ) Yes ( ) No

Associated History Information (Answer As Apply)

Last Grade Attended: Graduate: ( ) Yes ( ) No

Name/Address of School:

Department of social Services

Social Worker/Case Workers Name:

Social/Case Workers Phone#:

Source of Funding: ( ) Medicaid ( ) SSI ( ) Other: Provide Information

Identification Information (Indicate if the member needs an ID card, Copy ID, Med., etc. for file)

ID Card: ( )Yes ( ) No

Medicaid/Insurance Card: ( ) Yes ( ) No

Discharge Information:

Date of Discharge:

Reason for Discharge:

Name and Address of persons to whom the Client was discharged:

Forwarding address of the Client, if known:

Participation and Informed Choice: Yes

To ensure the individual's participation and *informed choice*, the provider shall explain to the individual or his/her authorized representative, as applicable, in a reasonable and comprehensible manner, the proposed services to be delivered, alternative services that might be advantageous for the individual, and accompanying risks or benefits. *The provider shall clearly document that this information was explained to the individual* or his/her authorized representative and the reasons the individual or his authorized representative chose the option included in the ISP.

Authorized Staff (CPSS) Signature

Date

Client's Signature/Legal Guardian

Date