

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

Open Inpatient Episode

Inpatient		CLIENT I.D.#
Last Name:		
First Name:		Middle:
Admit Date:		Procedure Code:
Other Factors: Physical? Yes <input type="checkbox"/> No <input type="checkbox"/> DD? Yes <input type="checkbox"/> No <input type="checkbox"/> Dual Diagnosis:		
Intent of Service: <input type="checkbox"/> Assessment <input type="checkbox"/> Improvement <input type="checkbox"/> Maintenance		
Primary Problem Area:		
Referral In Code:		Legal Status:
Referral In Provider:		
Treatment Authorization for Minor:		
Ward No.:		Patient File #:
Point of Origin:		

DIAGNOSIS Enter one Primary (required) and one Secondary Diagnosis (if applicable)

Primary	Secondary	ICD Code	Diagnosis (Nomenclature)

Provider Name: _____

Provider Number: _____