

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

AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V
			<input type="checkbox"/> 1. Primary Support Group	GAF/CGAS
			<input type="checkbox"/> 2. Social Environment	
			<input type="checkbox"/> 3. Educational	
			<input type="checkbox"/> 4. Occupational	
			<input type="checkbox"/> 5. Housing	
			<input type="checkbox"/> 6. Economic	
			<input type="checkbox"/> 7. Access to Health Care	
			<input type="checkbox"/> 8. Interaction with Legal System	
Primary:			<input type="checkbox"/> 9. Other Psychological/Environmental	
Secondary:			<input type="checkbox"/> 10. Inadequate Information	

Provider Name: _____

Provider Number: _____