cility (c .D.) _____

Reporting Month _____ 19 _____

☐ Check Here If NO Convulsive Treatment to Report

☐ Check Here If NO Psychosurgery to Report

I.D. NUMBER AND AGE		LEGAL STATUS				SEX		ETHNICITY						PAYMENT SOURCE				ECT etc.	COMPLICATIONS				DEATH	AUTOPSY
'atient's Hospital or Office) Number	Age	Vol. Patient with informed consent	Invol. Patient with informed consent	Vol. Patient incapable of consent	Invol. Patient incapable of consent	Female	Male	White	Black	Hispanic	Asian	American Indian	Other	PRIVATE	PUBLIC	3RD PARTY PAYOR	OTHER	TREATMENTS THIS MONTH	CARDIAC ARREST	FRACTURES	APNEA	MEMORY LOSS		
TOTALS																								

SUBMIT REPORT TO:

STAT CLERK
PATIENTS' RIGHTS OFFICE
Los Angeles County
Dept. of Mental Health
505 S. Virgil Ave.
Los Angeles, CA 90020

#202.12 Attachment I