

**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH**  
CONFIDENTIAL CLIENT INFORMATION PER CALIFORNIA WELFARE AND INSTITUTIONS CODE 5328  
AND HIPAA PRIVACY STANDARDS

## Open Outpatient Episode

<b>Outpatient</b>	<b>CLIENT I.D.#</b>
Last Name:	
First Name:	Middle:
Admit Date:	
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 Reporting Unit:	
Treatment Authorization for Minor:	
Patient File #:	
Primary Contact:	
CCCP Due Date:	

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

Primary	Secondary	ICD Code	Diagnosis (Nomenclature)

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_