



PLACEMENT INFORMATION

Client Name: _____

AKA/Nickname: _____ D.O.B.: _____

Male Female Marital Status: _____

UCI#: _____ Soc. Sec. #: _____

Language(s): _____

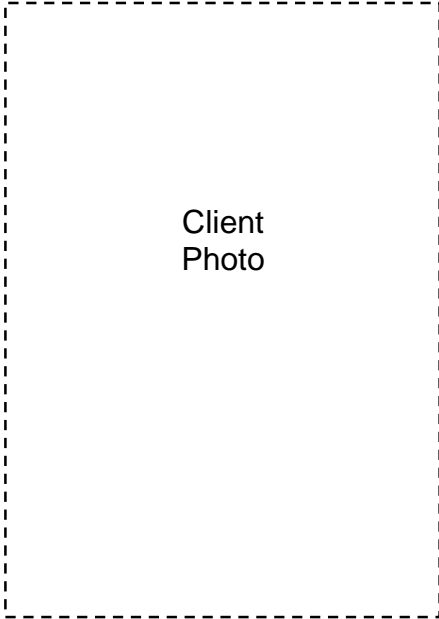
SSI _____ Payee: _____

SSA _____ Payee: _____

Other: _____ Payee: _____

Medi-Cal #: _____ Medi-Care #: _____

Other Insurance: _____



Client
Photo

DATE OF PLACEMENT: _____

FACILITY NAME: _____

Street Address: _____

City: _____ Zip Code: _____ Phone #: _____

PHYSICAL DESCRIPTION

Height: _____ Weight: _____
 Eyes: _____ Hair: _____
 Distinguishing Marks: _____
 Allergies: _____

PREVIOUS PLACEMENT INFORMATION

Street Address: _____

City: _____ Zip Code: _____

Phone #: _____

Contact: _____

PLACEMENT AGENCY: _____

Street Address: _____

City: _____ Zip Code: _____

Phone #: _____

Contact: _____

OTHER AGENCY: _____

Street Address: _____

City: _____ Zip Code: _____

Phone #: _____

Contact: _____

RELIGIOUS PREFERENCE: _____

Advisor: _____

Street Address: _____

City: _____ Zip Code: _____

Phone#: _____

BURIAL ARRANGEMENTS (if any):

LEGAL REPRESENTATIVE:

Name: _____ Relation: _____

Street Address: _____

City: _____ Zip Code: _____

Home #: _____ Work #: _____

OTHER REPRESENTATIVE:

Name: _____ Relation: _____

Street Address: _____

City: _____ Zip Code: _____

Home #: _____ Work #: _____

CONFIDENTIAL CLIENT INFORMATION
EASTERN LOS ANGELES
REGIONAL CENTER
See California Welfare &
Institutions Code, Section 4514

DOES THIS CLIENT HAVE ANY DANGEROUS PROPENSITIES? YES NO

If so, describe: _____

DIAGNOSIS:

MEDICAL NEEDS:

MEDICATIONS:

DOSAGE:

FREQUENCY:

PRESCRIBING MD:

PRIMARY PHYSICIAN: _____

Address: _____

City: _____ Zip Code: _____

Phone#: _____

DENTIST: _____

Address: _____

City: _____ Zip Code: _____

Phone#: _____

OTHER SPECIALIST: _____

Address: _____

City: _____ Zip Code: _____

Phone#: _____

OTHER SPECIALIST: _____

Address: _____

City: _____ Zip Code: _____

Phone#: _____

COMMUNICABLE CONDITIONS: (Hepatitis B, etc.)

SPECIAL INSTRUCTIONS: (weight monitoring, allergies, etc.)

VISITATION RESTRICTIONS:

Approval of Parent/Guardian/Conservator: _____ Date: _____

PERSON(S) AUTHORIZED TO TAKE CLIENT FROM THE HOME:

Approval of Parent/Guardian/Conservator: _____ Date: _____

OTHER SIGNIFICANT INFORMATION:

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