

LPS Conservatorship Referral

All information shall be completed to the extent available in facility records. Please indicate **N/A** when information is **Not Available**. Incomplete referrals will be returned.

REFERRING AGENCY

Name: _____

Name of Contact Person: _____ Phone: _____

Title of Contact Person: _____ Email: _____

CLIENT INFORMATION

Name: _____ DOB _____ Age: _____

Birthplace (City/State/Country) _____ Gender: _____

Religion: _____ Race: _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____ Social Security Number _____

Driver's License: _____ VA Claim Number: _____

Medicare Number: _____ Medi-Cal Number: _____

SSI Applied Date: _____ by: _____

Home address _____

Phone Number: _____ Residency: Years in California: _____ Years in Ventura Co. _____

PRESENT LEGAL STATUS

Date Admitted: _____ (check one) Voluntary Involuntary

Date 5150 Began _____ Date 5250 began: _____ Certified Hearing Date: _____

FAMILY HISTORY

Marital Status: Single Married Divorced Widowed Date of Marriage, Divorce, Widowed: _____

Spouse Name: _____ Phone Number: _____ Alternate Number: _____

Address: _____

Parents:

Father Name: _____ Phone Number: _____ Alternate Number: _____

Address: _____

Mother Name: _____ Phone Number: _____ Alternate Number: _____

Address: _____

Children:

Name: _____ Age: _____ Gender: _____

Phone Number: _____ Alternate Number: _____

Address: _____

Name: _____ Age: _____ Gender: _____

Phone Number: _____ Alternate Number: _____

Address: _____

Siblings:

Name: _____ Age: _____ Gender: _____

Phone Number: _____ Alternate Number: _____

Address: _____

Name: _____ Age: _____ Gender: _____

Phone Number: _____ Alternate Number: _____

Address: _____

FINANCIAL ASSETS

SSI Monthly Income: \$ _____ SSA Monthly Income: \$ _____

VA Monthly Income: \$ _____ Other Income: _____ Monthly Amount: \$ _____

List Name of Financial Institution and Account Information:

List Real Property (location):

List Personal Property: Type/Location:

PSYCHIATRIC HOSPITALIZATIONS

First Psychiatric Hospitalization Date: _____ Location: _____

Circumstances: _____

Number of recorded hospitalizations: _____

Other Hospital of record: _____

Axis I Diagnosis: _____

Axis III Diagnosis: _____

Current Psychotropic Medications: (If more space is needed attach separate list)

SIGNIFICANT CONDITIONS RELATED TO GRAVE DISABILITY

- Ability to feed self? Yes No
- Clothe self? Yes No
- Obtain Shelter? Yes No

Please give brief explanation:

Follows Prescribed Treatment for Disabling Conditions: Yes No

Accepts Third-Party Assistance in these areas: Yes No

It is recommended that the proposed conservatee shall or shall not have the following rights and privileges (W&I Code 5360): **Please give specific reasons when marked "Shall Not"**

Shall Shall Not
 a. Have the privilege of possessing a license to operate a motor vehicle.
Reason: _____

Shall Shall Not
 b. Have the right to enter into contracts.
Reason: _____

Shall Shall Not
 c. Have the right to refuse to consent to treatment related specifically to the conservatees grave disability.
Reason: _____

Shall Shall Not

d. Have the right to refuse or consent to routine medical treatment not related to the conservatee's grave disability.

Reason: _____

Shall Shall Not

e. Have the right to vote pursuant to Section 707.5 of the Elections Code.

Reason: _____

Shall Shall Not

f. Have the right to own or possess a firearm.

Reason: _____

RECOMMENDED PLACEMENT WHICH IS LEAST RESTRICTIVE AND MOST APPROPRIATE FOR THIS PERSON UPON DISCHARGE:

Check all that apply:

Independent living **Residential Living Facility-** Supervision, self-administers medication

Board and Care- Care and supervision, medication administration needed.

Name of Board and Care: _____

Open Treatment Facility- Care and supervision, nursing care, psychiatric rehabilitation.

Name of Facility: _____

Locked Treatment Facility- High risk behaviors, nursing care, psychiatric rehabilitation.

Name of Facility: _____

Acute (locked) psychiatric treatment facility- Danger to Self or Others, Symptom Reduction

Name of Facility: _____

TREATMENT PLAN

(A brief, but specific outline of goals, objectives, and recommended treatment during period of conservatorship)

Goals:

Objectives:

Recommended Treatment:

Important: You may send the referral form and corresponding attachments by email to HSA-PAPG-Referrals@ventura.org. Forms with original physician/psychiatrist signature must be delivered or mailed to:

Public Guardian County of Ventura
1001 Partridge Dr. Suite 360
Ventura CA, 93003

ATTACHMENT 1

NOTICE OF REQUEST FOR TEMPORARY LPS CONSERVATOR

Name: _____ DOB: _____ Gender: _____

Address: _____ SSN: _____
(Residence of proposed conservatee)

I am the treating psychiatrist for the above named patient. I am requesting that said patient be placed on an LPS Temporary Conservatorship which, if granted, will extend the patient's hospitalization for up to an additional 30 days.

I have personally informed my patient that I have requested an LPS Temporary Conservatorship thereby extending his or her hospitalization for up to an additional 30 days and that if the patient objects he or she should contact the Public Defender or the Patient's Rights Advocate.

I have also informed the patient that I intend to continue treatment with psychotropic medications and that if the patient objects he or she should contact the Public Defender or the Patients' Rights Advocate.

I informed the patient on _____, 20____ at _____ (am/pm)
(Month) (Day) (Year) (Time)

At _____
(Name of Facility)

Executed on (date) _____ at _____ California

I Declare under penalty of perjury that the foregoing is true and correct

Signature of Physician

Print or Type Name & Title

Confidential Patient Information See Welfare & Institutions Code Section 5328

ATTACHMENT 2

RECOMMENDATION FOR LPS CONSERVATORSHIP

Name: _____ DOB: _____ Gender: _____

Address: _____ SSN: _____
(Residence of proposed conservatee)

The above-named is a patient in a designated intensive treatment facility:

(Name of Facility)

I am recommending temporary and permanent LPS conservatorship be established because the patient is gravely disabled as a result of:

A Mental Disorder Chronic Alcoholism

(Cross out inapplicable phrases in the following paragraphs)

In that he/she is unable to provide for his/her basic personal needs for food, clothing, and shelter and is either unwilling to accept or incapable of accepting treatment voluntarily. His/her disability is such that he/she must be under the supervision of someone with authority to ensure that his/her basic personal needs will be provided on either a voluntary or involuntary basis. A Temporary conservator should be appointed should it not be possible to appoint a permanent one before the expiration of the time allowed for intensive treatment.

This patient requires treatment with psychotropic medications.

He/she is not aware of his/her current mental condition and is unable to understand the risks, the benefits, or the alternatives to treatment with psychotropic medications. Additionally, he/she is unable to understand and to knowingly and intelligently evaluate information required to give informed consent regarding psychotropic medications.

Additional reasons for this recommendation for conservatorship and additional information about the patient are set forth in the Medical Summary attached hereto and made part hereof by reference.

Executed on (date) _____ at _____ California

I declare under penalty of perjury that the foregoing is true and correct

Signature of Physician

Print or Type Name & Title

Signature of Person in Charge of Facility

Print or Type Name & Title

Confidential Patient Information See Welfare & Institutions Code Section 5328