|  |  |
| --- | --- |
| Client Name:  |  |
| SID Number:  |  |
| Care Identification #:  |  |
| DOB:  |  |
| Last Four Digits of SSN:  |  |
| Previous Assessment (ANSA) or (CANS): LIDDA assessment: \*To include but not limited to crisis assessment |  |
| Previously recommended treatment:  |  |
| Most recent diagnosis(es) and date:  |  |
| Is the client acutely (at time of assessment) decompensated, suicidal, or homicidal according to self-report?  | Yes / No If yes, explain:  |
|  |
| Other relevant information pertaining to Mental Health History:  |  |
| Current County or Municipality of Incarceration:  |  |
| Name of Person Submitting Form and Date:  |  |
| ***MAGISTRATE IS NOT REQUIRED TO ORDER THE COLLECTION OF INFORMATION IF THE DEFENDANT IN THE YEAR PROCEEDING THE DATE OF APPLICABLE ARREST HAS BEEN DETERMINED TO HAVE A MENTAL ILLNESS OR INTELLECTUAL DISABILITY BY THE LOCAL MENTAL HEALTH AUTHORITY, LOCAL INTELLECTUAL DEVELOPMENTAL DISABILITY AUTHORITY, OR ANOTHER MENTAL HEALTH OR INTELLECTUAL DISABILITY EXPERT.***  |

Updated 9/1/21

Contents of this form remain confidential as applicable under Health and Safety Code § 614.017