|  |  |
| --- | --- |
| 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