



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
SAN GABRIEL/POMONA VALLEYS
DEVELOPMENTAL SERVICES, INC.
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: _____

DENTIST: _____

Address: _____

Address: _____

City: _____ Zip Code: _____

City: _____ Zip Code: _____

Phone#: _____

Phone#: _____

OTHER SPECIALIST: _____

OTHER SPECIALIST: _____

Address: _____

Address: _____

City: _____ Zip Code: _____

City: _____ Zip Code: _____

Phone#: _____

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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