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 DISABLITY

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