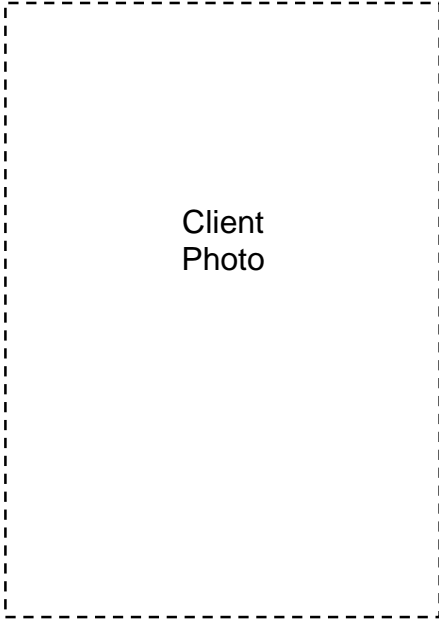


**PLACEMENT INFORMATION**

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: \_\_\_\_\_



**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

**Continued on page 2**

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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