EASTERN LOS ANGELES
REGIONAL CENTER

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 #: _____

Client Photo

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
EASTERN LOS ANGELES
REGIONAL CENTER
See California Welfare &
Institutions Code, Section 4514

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DOES THIS CLIENT HAVE ANY DANGEROUS PROPENSITIES? ☐ YES ☐ NO

If so, describe: _____

DIAGNOSIS:

_____

_____

_____

MEDICAL NEEDS:

_____

_____

_____

MEDICATIONS:	DOSAGE:	FREQUENCY:	PRESCRIBING MD:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIMARY PHYSICIAN: _____

Address: _____

City: _____ Zip Code: _____

Phone#: _____

DENTIST: _____

Address: _____

City: _____ Zip Code: _____

Phone#: _____

OTHER SPECIALIST: _____

Address: _____

City: _____ Zip Code: _____

Phone#: _____

OTHER SPECIALIST: _____

Address: _____

City: _____ Zip Code: _____

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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