



### CARE REPORT | INITIAL HEARING

<b>FROM: <u>BHS CARE TEAM</u></b>	
<b>TO: SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO</b>	
<input type="checkbox"/> CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., SAN DIEGO, CA 92101 <input type="checkbox"/> EAST COUNTY DIVISION, 250 E. MAIN ST., EL CAJON, CA 92020 <input type="checkbox"/> NORTH COUNTY DIVISION, 325 S. MELROSE DR., VISTA, CA 92081 <input type="checkbox"/> SOUTH COUNTY DIVISION, 500 3 <sup>RD</sup> AVE., CHULA VISTA, CA 91910	
ATTN: _____	
<b>RESPONDENT:</b>	
NAME: _____	
PETITION # _____	CERNER #: _____
COURT DATE: _____ TIME: _____	
<b>ORIGINATING PETITIONER:</b>	
NAME: _____	
<b>BHS RECOMMENDATION TO THE COURT:</b>	
<b>INITIAL HEARING REPORT VERSION NO.</b>	<b>REASON FOR REVISION:</b>
<b>ATTACHMENTS:</b>	
<input type="checkbox"/> FACE SHEET <input type="checkbox"/> DECLARATION BY A LICENSED BEHAVIORAL HEALTH PROFESSIONAL (FORM <input type="checkbox"/> CARE-101) CARE REPORT  INVESTIGATION <input type="checkbox"/> CARE REPORT  INITIAL HEARING <input type="checkbox"/> CARE PLAN <input type="checkbox"/> AMENDED CARE PLAN <input type="checkbox"/> CARE REPORT  STATUS REVIEW <input type="checkbox"/> CARE REPORT  ONE YEAR STATUS REVIEW <input type="checkbox"/> CARE GRADUATION PLAN <input type="checkbox"/> OTHER:	
<b>NOTES:</b>	



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**RESPONDENT INFORMATION:**

Petition #: \_\_\_\_\_  
 Cerner #: \_\_\_\_\_  
 Respondent's Name: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_  
 Primary Address: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_  
 Court Location: \_\_\_\_\_  
 Pronouns: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Court Date: \_\_\_\_\_  
 Court Time: \_\_\_\_\_

**SUPPORTER INFORMATION (if applicable):**

Supporter's Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Primary Language: \_\_\_\_\_  
 State: \_\_\_\_\_  
 ZIP Code: \_\_\_\_\_

**ORIGINATING PETITIONER INFORMATION (Original Petition to Supreme Court):**

Category of Petitioner: \_\_\_\_\_  
 Petitioner's Name: \_\_\_\_\_  
 Petitioner's Organization/Affiliation: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Petitioner's Relationship to Respondent: \_\_\_\_\_  
 Date Petition Filed w/ Court: \_\_\_\_\_  
 Date Prima Facie established by Court: \_\_\_\_\_  
 Date Order for Investigation sent to BHS CARE Court Team: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 City: \_\_\_\_\_  
 ZIP Code: \_\_\_\_\_  
 Time: \_\_\_\_\_  
 Time: \_\_\_\_\_

**APPOINTED COUNSEL INFORMATION**

Appointed Counsel Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 State: \_\_\_\_\_  
 ZIP Code: \_\_\_\_\_

Respondent has signed a Release of Information.

See ROI(s) Attached



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**NOTICE | PROOF OF SERVICE:**

	<i>CARE-110</i>	<i>CARE-111</i>	<i>CARE-113</i>	<i>CARE-060-INFO</i>	<i>BHS POS</i> (If No <i>CARE-110</i> )	<i>PETITION AND REPORT</i>
<b>Respondent</b>	<input type="checkbox"/> Attached	<input type="checkbox"/> Attached				
<b>Respondent's Counsel</b>	<input type="checkbox"/> Attached				<input type="checkbox"/> Attached	<input type="checkbox"/> Attached
<b>Non-BHS Petitioner</b>	<input type="checkbox"/> Attached				<input type="checkbox"/> Attached	
<b>Non-BHS Petitioner's Counsel</b>	<input type="checkbox"/> Attached				<input type="checkbox"/> Attached	
<b>Out of County Behavioral Health Agency</b>	<input type="checkbox"/> Attached				<input type="checkbox"/> Attached	
<b>Out of County Behavioral Health Agency Counsel</b>	<input type="checkbox"/> Attached				<input type="checkbox"/> Attached	

**CARE ENGAGEMENT LOG:**

Date	Method (Face to Face, Phone, Televideo, email)	Outreach and Engagement Team Member	Who was contacted? (Client, Collateral, Tx Provider)	Contact Made (Yes/No)	Information Obtained

Does Respondent have the ability to voluntarily engage in services?    Yes       No       Unable to determine

Summarize what was done to engage the Respondent and the result of that engagement:



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The following additional/updated information has been received since the petition was filed and/or the Investigation Report was completed:

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### FINDINGS:

Based on evidence collected and reviewed and engagement or lack thereof with the Respondent, the BHS CARE Court team has determined the following:

A CARE Plan is NOT recommended due to being unable to determine/unable to locate/contact the Respondent.

A CARE Plan is NOT recommended, as the Respondent does not meet eligibility criteria

A CARE Plan is NOT recommended, as the Respondent is likely to voluntarily enroll in treatment.

A CARE Plan IS recommended, as the Respondent meets CARE eligibility criteria and is likely to benefit from CARE proceedings



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Date: \_\_\_\_\_

\_\_\_\_\_  
Print Clinician Name, Title, Program

\_\_\_\_\_  
Signature of Clinician

**ATTACHMENTS:**

- Release of Information
- Behavioral Health Assessment
- Behavioral Health treatment records
- Medication Records
- Psychiatric Assessment
- Client/Service Plan
- Physician Orders
- Diagnosis
- Billing records
- History & Physical Exam
- Alcohol/Drug Treatment Records
- Laboratory Results
- Medical Records/Imaging/Procedures
- Progress Notes
- Pharmacy Records
- Psychological Evaluation
- Nursing Notes
- Other: