List of Records Regional Centers May Ask for When You Apply for Services

The regional center may ask you for the information listed below. If you copy this form and fill it out, it will help you to be ready when you apply for services.

If you have any questions about these records, call OCRA or Disability Rights California.

About You
Name: ____________________________________________
Address: ____________________________________________
                                      street        city        state        zip code
Phone number: ________________________________
Parent or Guardian’s name: __________________________

Your Medical Records
Bring copies of any health benefits cards under which you are eligible to receive health benefits, including private health insurance coverage, health service plans, Medi-Cal, Medicare, and TRICARE cards (for military families).

List each doctor, psychologist or other health care provider who has cared for you:

1. Doctor’s name: ___________________________ Phone #:________________
   Address: ____________________________________________
            street        city        state        zip code

2. Doctor’s name: ___________________________ Phone #:________________
   Address: ____________________________________________
            street        city        state        zip code

3. Doctor’s name: ___________________________ Phone #:________________
   Address: ____________________________________________
            street        city        state        zip code

4. Doctor’s name: ___________________________ Phone #:________________
   Address: ____________________________________________
            street        city        state        zip code
5. Doctor’s name: ___________________________ Phone #:_____________
Address: ___________________________________________________________

street          city          state          zip code
Hospitals and Clinics
List each hospital or clinic where you received care, including where you were born:

1. Name of Hospital or Clinic: ____________________ Phone #: _____________
   Address: ____________________________________________________________
   street    city    state    zip code

2. Name of Hospital or Clinic: ____________________ Phone #: _____________
   Address: ____________________________________________________________
   street    city    state    zip code

3. Name of Hospital or Clinic: ____________________ Phone #: _____________
   Address: ____________________________________________________________
   street    city    state    zip code

4. Name of Hospital or Clinic: ____________________ Phone #: _____________
   Address: ____________________________________________________________
   street    city    state    zip code

5. Name of Hospital or Clinic: ____________________ Phone #: _____________
   Address: ____________________________________________________________
   street    city    state    zip code

6. Name of Hospital or Clinic: ____________________ Phone #: _____________
   Address: ____________________________________________________________
   street    city    state    zip code

Medications
Many consumers take lots of medication. List all medications you have taken:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Medications you take now: ____________________________________________
Early Start/Head Start Records

School Records
List each school you have attended:

1. Name of School: ____________________________ Phone #: ________________
   (Check one): ☐ Preschool ☐ Elementary School ☐ Middle school ☐ Other
   Address: ________________________________________________
   street   city   state   zip code

2. Name of School: ____________________________ Phone #: ________________
   (Check one): ☐ Preschool ☐ Elementary School ☐ Middle school ☐ Other
   Address: ________________________________________________
   street   city   state   zip code

3. Name of School: ____________________________ Phone #: ________________
   (Check one): ☐ Preschool ☐ Elementary School ☐ Middle school ☐ Other
   Address: ________________________________________________
   street   city   state   zip code

4. Name of School: ____________________________ Phone #: ________________
   (Check one): ☐ Preschool ☐ Elementary School ☐ Middle school ☐ Other
   Address: ________________________________________________
   street   city   state   zip code

5. Name of School: ____________________________ Phone #: ________________
   (Check one): ☐ Preschool ☐ Elementary School ☐ Middle school ☐ Other
   Address: ________________________________________________
   street   city   state   zip code

6. Name of School: ____________________________ Phone #: ________________
   (Check one): ☐ Preschool ☐ Elementary School ☐ Middle school ☐ Other
   Address: ________________________________________________
   street   city   state   zip code