Behavioral Health Department
Alameda County Health

Vocational Program
Address: 7200 Bancroft Ave, Suite 125B Oakland, CA 94605
Phone: (510)777-4240, **Fax:** (510)777-4244
Email: VocReferrals@acgov.org

Referral Source

Referring Clinic: Tri-City Mental Health (Makan Talayeh MD)

Case Manager: Not applicable **Phone Number:** (510) 794-2434

Client Information

Last Name: Adeniji **First:** kehinde **M:** Adewumi

Preferred name / Pronoun: Ken He/Him **Phone Number:** (510) 796-8121

Date of Birth: 1967-10-15 **SSN:** 238-45-6766 **Client ID:** 75091537

Address: 4762 Canvasback Common **Apt#:** **City:** Fremont **Zip:** 94555

Emergency Contact (Name and Phone Number) : Daniel Adeniji (510) 796-8121

Demographic Information

(See Codes list for details)

Sex: Male **Marital Status:** Never Marr **Gender Identity:** Male **Sexual Orientation:** Heterosexu

Ethnicity: Non-Hispanic **Race:** Black or African American

Place of Birth – Country: Nigeria **Place of Birth (US) State:** Lago **Place of Birth (US) County:** Lagos

Living Arrangement:
Living: House/Apartment (Living arrangement of the client)

Educational/Employment:
Educational Status: Doctorate candidate (Client's Highest Level of Education)
Goal: To complete my doctorate

Employment Status: Unemployed (Client's Current Employment Status)
Goal: To best utilize my time, and be more productive

Language:
Primary / Preferred Language: EEnglish Hispanic Origin: Not app indicate the client's Hispanic Origin)

Diagnosis

ICD-10 Dx 1: **ICD-10 Dx 2:** **ICD-10 Dx 3:**

Diagnosis Established by: Name and License:

Client Trauma:

General Medical Condition(s) 1: _____2: _____ 3: _____

Substance Abuse/Dependence Issue? _____ If Y*es* - Substance abuse diagnosis **(F10-F19.99)** _____

Codes

General Medical Conditions:

Allergies	Cirrhosis	Hyperlipidemia	Physical Disability
Anemia	Cystic Fibrosis	Hypertension	Psoriasis
Arterial Sclerotic Disease	Deaf/Hearing Impaired	Hyperthyroid	STD
Arthritis	Diabetes	Infertility	Stroke
Asthma	Digestive Disorder (IBS)	Migraines	Tinnitus
Birth Defect	Ear Infection	Multiple Sclerosis	Ulcers
Blind / Visually Impaired	Epilepsy/Seizures	Muscular Dystrophy	Unknown
Cancer	Heart Disease	Obesity	Other
Carpal Tunnel Syndrome	Hepatitis	Osteoporosis	No General Medical Con.
Chronic Pain	Hypercholesterolemia	Parkinson's Disease	

Notes / Requests:

Signatures

I hereby authorize that my medical & psychiatric records and relevant information be released from my referring agency to The Alameda County –BHCS - Vocational Program for the purpose of vocational planning, employment placement, guidance, and assessment. This also includes my authorization for conversations to take place between my referring agency/counselor and ACVP as needed to achieve my vocational goals.

Client Signature: Kehinde Adewumi Adeniji **Date:** 2024-10-25T10:00:00

I agree to partner with the Vocational Program to assist this consumer in achieving their employment objectives by continuing to provide resources and support within my scope of practice:

Referring Provider Signature and Title: _____

Please submit the following from the client at the time of referral

1) Driver's License, Passport, or Green Card. 2) Social Security Card. 3) Mental Health Assessment.