Child Crisis Stabilization Services- St. Joseph's Villa

Referral Screening Form

To be completed by Referral Source: CSB and Direct Access (DA)

CSB/BHA: ______________________________________ DA: ___________________________
Referral Source: _____________________ Phone Number: _____________________
Date: ___________________________ Time Start: ___________ Time End: __________

PERSONAL INFORMATION

Client Name: ______________________________ ID# _______________ D.O.A. __________ _______
Date of Birth: ________________________ Age: ________________ Gender: _______________________
SS#: ____________________ Race: _______________________ Height: _______ Weight: ___________
Address: ____
Emergency Contact: _____________________ (relationship) _______________ Phone #:______________
Emergency Contact Address: ____
CSB of residence: ______________________________

Biological/Adopted Mother (name, address, phone): ____
____
____

Biological/Adopted Father (name, address, phone): ____
____
____

Legal Guardian(s) (name, address, phone): ____
____
____

Medicaid: [ ] Yes [ ] No Medicaid #: _______________________________ Copy of card: [ ] Yes [ ] No
Private Insurance:
[ ] Yes [ ] No Policy #: ___________________ Group #: ________________ Copy of card: [ ] Yes [ ] No
No Insurance: __________________

PAST BEHAVIORAL HEALTH TREATMENT/AGENCY INVOLVEMENT

(Indicate agencies at which services received, dates, hospitalizations, results/response to treatment, other agencies currently involved, frequency, & duration).

Client Inpatient Treatment:

Have you **ever** been hospitalized for mental health or substance abuse reasons? ___ No ___ Yes

If Yes - List previous **INPATIENT** treatment and indicate if successful in *Comments*. *(include hospitalizations and/or residential treatment facilities)*

Date	Facility	LOS	Physician	Reason/Comments

Client Outpatient Treatment:

Have you **ever** received outpatient treatment for mental health or substance abuse reasons? ___ No ___ Yes

If Yes - List previous **Outpatient** treatment and indicate if successful in *Comments*. *(include current/past intensive in-home)*

Name Psychiatrist/Therapist	Date Last Visit	Frequency of Visits	Reason for Visits	Comments

Client Types of Treatment Received:

If Yes to previous Inpatient or Outpatient Treatment, check Types of Previous or Current Treatment:

__ Medication __ Individual Tx __ Couple Tx __ Family Tx __ Group Tx __ AA mtg. __NA mtg.

__ Other: *Name*____

MENTAL STATUS EXAM

(check items that apply)

<table>
<tr><td>Appearance</td><td>WNL</td><td>Unkempt</td><td>Poor Hygiene</td><td>Bizarre</td><td>Tense</td><td>Rigid</td></tr>
<tr><td>Behavior/Motor Disturbance</td><td>WNL</td><td>Agitation</td><td>Guarded</td><td>Tremor</td><td>Manic</td><td>Impulse Control</td><td>Psychomotor Retardation</td></tr>
<tr><td>Orientation</td><td>WNL</td><td>Disoriented To</td><td>Time</td><td>Place</td><td>Person</td><td>Situation</td></tr>
<tr><td>Speech</td><td>WNL</td><td>Pressured</td><td>Slowed</td><td>Soft</td><td>Loud</td><td>Slurred</td><td>Incoherent</td></tr>
<tr><td>Mood</td><td>WNL</td><td>Depressed</td><td>Angry/Hostile</td><td>Euphoric</td><td>Anxious</td><td>Anhedonic</td><td>Withdrawn</td></tr>
<tr><td>Range of Affect</td><td>WNL</td><td>Constricted</td><td>Blunted</td><td>Flat</td><td>Labile</td><td>Inappropriate</td></tr>
<tr><td>Thought Content</td><td>WNL</td><td>Impaired</td><td>Unfocused</td><td>Unreasonable</td><td>Preoccupation</td><td>Delusions</td></tr>
<tr><td></td><td>Phobias</td><td>Thought Insertion</td><td>Grandiose</td><td>Ideas of Reference</td><td>Paranoid</td><td>Obsessions</td></tr>
<tr><td>Thought Process</td><td>WNL</td><td>Illogical</td><td>Abstract</td><td>Concrete</td><td>Incoherent</td><td>Perseverative</td></tr>
<tr><td></td><td></td><td>Impaired Concentration</td><td>Loose Associations</td><td>Flight of Ideas</td><td>Circumstantial</td><td>Blocking</td></tr>
<tr><td>Sensory</td><td>WNL</td><td>Illusions</td><td>Flashbacks</td><td>Hallucinations</td></tr>
<tr><td>Memory</td><td>WNL</td><td>Impaired</td><td>Recent</td><td>Remote</td><td>Immediate</td></tr>
<tr><td>Appetite</td><td>WNL</td><td>Increased</td><td>Decreased</td><td>Weight:</td><td>Stable</td><td>Loss</td><td>Gain</td></tr>
<tr><td>Sleep</td><td>WNL</td><td>Hypersomnia</td><td>Onset Problem</td><td>Maintenance Problem</td></tr>
<tr><td>Insight</td><td>WNL</td><td>Blaming</td><td>Little</td><td>None</td></tr>
<tr><td>Judgment</td><td></td><td>Good</td><td>Impaired</td><td>Poor</td></tr>
<tr><td colspan="2">Estimated Intellectual Functioning:</td><td>Above Average</td><td>Average</td><td>Below Average</td><td>Diagnosed ID</td><td>Unable to Determine</td></tr>
<tr><td colspan="3">Able to provide historical information</td><td>Yes</td><td>No</td><td>Explain</td></tr>
<tr><td colspan="2">Reliability of self report</td><td>Good</td><td>Fair</td><td>Poor</td><td>Explain</td></tr>
</table>

Lethality:

Currently thinking of or recent thought of harming yourself? [ ] No [ ] Yes ***If Yes,*** *describe plan, opportunity, triggering incident, most recent time, and timeframe:* ____

____

History of: Past Suicide Attempts? [ ] No [ ] Yes Self-Destructive Behavior? [ ] No [ ] Yes **If Yes to Either,** *Describe:* ____

Ability to contract for safety? [ ] No [ ] Yes

Violent/Homicidal Risk? [ ] No [ ] Yes **If Yes,** *Who & How?* ______________________________

Have you ever been physically or sexually abused? [ ] No [ ] Yes **If Yes to Either,** *Describe:* ______________

____

Preliminary Diagnosis: (*this diagnosis is based on the review of clinical documentation and interview with the Client/guardian and referral source*)

____

____

SUBSTANCE USE/LEGAL HISTORY

(*check if individual currently uses*)

Substance	Age of Onset	Type/Method	Amount/Frequency	How Long at Current Amount	Last Use

Withdrawal Symptoms: __ No __ Yes If *Yes, Name?*______________________________

Family History of Substance Use: __ No __ Yes If *Yes, Who?* ______________________________

____

In the last 24 hours: [ ] Tremors [ ] Seizures [ ] Blackouts [ ] Headaches [ ] Vomiting [ ] Nausea [ ] Diarrhea
[ ] Sweating [ ] Paranoia [ ] DTs [ ] Other: ______________________________

Have you ever received any inpatient or outpatient SA treatment: [ ] Yes [ ] No
If yes, name of facility and location? ______________________________

Legal Data:

Legal Issues: *(indicate Client's criminal justice status)*

Y N Pending charges: (see comments)
Y N Currently on probation
Y N Current probation violations
Y N Court hearing: (date/jurisdiction) ____________________
Y N Past convictions: (see comments)
Y N Past incarcerations: (see comments)

Describe pending legal charges: ______________________________

Juvenile Detention: __ No __Yes *If Yes:* ___#
Reason(s):______________________________
Other: ______________________________
Probation/Parole Officer (name/number): ______________________________
GAL (name/number): ______________________________

Total number of arrests in past 30 days: ___________
[ ] no legal problems
[ ] now on parole/probation
Violation(s): ______________________________
Jurisdiction: ____________________
GAL: ____________________ **phone number:** ____________________
Parole/Probation officer: ____________________ **phone number:** ____________________

MEDICAL INFORMATION

Primary Care Physician: ______________________________ Phone: ______________________________
Last Seen: ______________________________
Medical History: ______________________________

Current & Past Medications taken within last six months: *Include over the counter.*

Name	Dose	Frequency	Side Effects	Prescribing Physician

Name	Dose	Frequency	Side Effects	Prescribing Physician

Taking as Prescribed? [ ] Yes [ ] No If *No, Explain:* ____

CSU Exclusionary Criteria ***(reviewed on a case by case basis):***
[ ] Unable to consent to treatment/unwilling to participate in treatment
[ ] Imminent danger to self/others (actively suicidal/homicidal)
[ ] Executable plan for suicide (at CSU)
[ ] Actively violent/aggressive within last 24 hours
[ ] Medically unstable/fragile (circle all that apply):

- Severe burns that cannot be cared for at home
- Altered mental status and unable to participate in treatment
- Overdose requiring medical clearance
- Acute Head trauma requiring medical attention
- Unstable fractures (open or closed) and/or joint dislocations
- Seizure within 24 hours
- Unexplained GI issues
- Bowel Obstruction
- Acute Respiratory Distress (shortness of breath, chest pains, asthma attack within 24 hours)
- Acute Drug Withdrawal
- Active GI Bleed
- Infectious Disease Requiring Isolation/Treatment by IV Antibiotics
- Active lice without treatment
- Draining Wound (open wound, requires daily complex wound care)
- Severe Eating Disorder requiring medical personnel to monitor

[ ] Unable to manage/perform ADL's
[ ] Requires 1:1 monitoring
[ ] Sex Offense: victim or perpetrator (review on case by case)
[ ] History of fire-setting (review on case by case)

Reason for Referral: ____
____
____
____
____
____
____
____

Final Disposition/Significant Clinical Information: ______________________________
____
____

Signature of Prescreener/Evaluator: ______________________________

Print Name: ______________________________ **Date:** ____________________