Child Crisis Stabilization Services- St. Joseph's Villa

Screening Form (rev. 8.10.20.23)

To be completed by Referral Source: CSB

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)

Appearance	WNL	Unkempt	Poor Hygiene	Bizarre	Tense	Rigid	
Behavior/Motor Disturbance	WNL	Agitation	Guarded	Tremor	Manic	Impulse Control	Psychomotor Retardation
Orientation	WNL	Disoriented To	Time	Place	Person	Situation	
Speech	WNL	Pressured	Slowed	Soft	Loud	Slurred	Incoherent
Mood	WNL	Depressed	Angry/Hostile	Euphoric	Anxious	Anhedonic	Withdrawn
Range of Affect	WNL	Constricted	Blunted	Flat	Labile	Inappropriate	
Thought Content	WNL	Impaired	Unfocused	Unreasonable	Preoccupation	Delusions	
	Phobias	Thought Insertion	Grandiose	Ideas of Reference	Paranoid	Obsessions	
Thought Process	WNL	Illogical	Abstract	Concrete	Incoherent	Perseverative	
		Impaired Concentration	Loose Associations	Flight of Ideas	Circumstantial	Blocking	
Sensory	WNL	Illusions	Flashbacks	Hallucinations			
Memory	WNL	Impaired	Recent	Remote	Immediate		
Appetite	WNL	Increased	Decreased	Weight:	Stable	Loss	Gain
Sleep	WNL	Hypersomnia	Onset Problem	Maintenance Problem			
Insight	WNL	Blaming	Little	None			
Judgment		Good	Impaired	Poor			
Estimated Intellectual Functioning:		Above Average	Average	Below Average	Diagnosed ID	Unable to Determine	

Able to provide historical information		Yes	No	Explain
Reliability of self report	Good	Fair	Poor	Explain

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 Court hearing: (date/jurisdiction) _____

Y N Currently on probation Y N Past convictions: (see comments)

Y N Current probation violations 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):

EXCLUSION CRITERIA: Pediatric Admission to State Hospitals & Crisis Stabilization Units

Criteria for Exclusion;

1 Burns (severe) requiring acute care; if the burn could be cared for at home, it is not an exclusion.
2 Acute Delirium.
3 Acute Head Trauma/Traumatic Brain Injury in absence of a mental illness.
4 Unstable fractures, open or closed and joint dislocations, acute, until reduced.
5 Unstable seizure disorders.
6 Bowel obstruction, requiring active treatment or medical observation.
7 Acute Respiratory Distress.
8 Acute drug intoxication, withdrawal, or high-risk for complicated withdrawal, including history of delirium tremens.
9 Active GI bleed and/or active bleeding from other unknown sites.
10 Active TB; other infectious disease requiring isolation and/or treatment by IV antibiotics to be discussed by providers based on facility's ability to provide.
11 Intravenous fluids or IV antibiotics
State Hospitals & CSUs are not a safe environment for managing intravenous fluids or IV antibiotics.
12 Draining wound, open, requiring daily complex wound care.
13 Vent and Trach patients excluded; other oxygen dependent patients based on facility's ability to provide care (e.g. BiPAP, CPAP at night, Oxygen Concentrator).
14 Tubes or drains, chest or abdominal, including ostomies (unless the individual provides their own ostomy care).
15 Hemodialysis patients excluded. Peritoneal dialysis patients based on facility's ability to safely manage patient.
16 Individuals requiring hospice or end of life care.
17 For Crisis Stabilization Units only: Durable medical equipment that is not able to be secured by facility.

- Severe Eating Disorder requiring medical personnel to monitor

[ ] Unable to manage/perform ADL's
[ ] Sex Offense: perpetrator
[ ] History of fire-setting (additional information on specifics & risk while in CSU environment).
[ ] Requires 1:1 monitoring due to high-risk behaviors too acute to provide safety of person referred and peers on the Unit.

Reason for Referral: _____

_____
_____
_____
_____
_____
_____
_____

Final Disposition/Significant Clinical Information: _____
_____
_____

Signature of Prescreener/Evaluator: _____

Print Name: _____ Date: _____