**County of San Diego Mental Health Services**

**INITIAL SCREENING**

**\*Client Name:**       **\*Case #:**

**\*Initial Screening Date:**       **\*Program Name:**

\*Type of Contact: [ ]  Telephone [ ]  Face-to-Face

Informant Name:

Relation to Client *(Select from Relationship Table located in the Instruction Sheet)*:

\*Is the client under 18? [ ]  Yes [ ]  No

**PARENTAL INFORMATION:**

Parent Name:       Relationship *(Select from Relationship Table located in the Instruction Sheet)*:

Address:       Phone:

City/State/Zip:

Employment Phone

Other Information *For additional responsible parent/guardian(s), enter “See Contacts Field Below”. Enter any other information that might be helpful in this field.*

**LEGAL INFORMATION**

Legal Consent: *(Select from Legal Status Table located in the Instruction Sheet)*       If other:

Responsible Person:

Relationship *(Select from Relationship Table located in the Instruction Sheet)*:

Address:       Phone:

City/State/Zip:

Employment Phone:

Other Information *Enter other information as needed:*

**CLIENT INFORMATION:**

Client’s Physical Address:

City/State/Zip:

Home Phone:       Work Phone:

Whom can we call back?

**\*PRESENTING PROBLEM:** *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.*

\*Urgency Level: [ ]  Routine [ ]  Emergency [ ]  Urgent [ ]  Unspecified/Unknown

[ ]  Initiate Second Effort Assigned Staff:

Date Second Effort Initiated:

Comments for Second Effort:

\* Client Requests/Needs: *Check all that apply:*

[ ]  Psychiatric Assessment [ ]  Psychotherapy [ ]  Mental Health Assessment [ ]  Other

Is client currently taking medications: [ ] Yes [ ]  No

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Med | Start Date | Is Date Estima-tedY or N | Dosage/Frequency | Amt. Prescribed | TargetSxs | Taken as Pre-scribed?Y, N or Unk | Prescribing Physician Name | \*\* | Refills | Stop Date | Reason for Stopping |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
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| ***\*\*Physician Type****: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP* |

History of Treatment: [ ]  Outpatient [ ]  Inpatient [ ]  Psychiatric Medications

**POTENTIAL FOR HARM/RISK ASSESSMENT**

\*Current Suicidal Ideation? [ ]  No [ ] Yes [ ] Unknown/Refused

Specify plan (vague, passive, imminent):

Access to Means? [ ]  No [ ] Yes [ ] Unknown/Refused

Describe:

Previous Attempts? [ ]  No [ ] Yes [ ] Unknown/Refused

Describe:

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

 [ ]  No [ ] Yes [ ] Unknown/Refused

Explain:

\*Current Homicidal Ideation? [ ]  No [ ] Yes [ ] Unknown/Refused

Specify plan (vague, intent, with/without means):

Identified Victim(s)? [ ]  No [ ] Yes Tarasoff Warning Indicated? [ ]  No [ ] Yes

Reported To:       Date:

Victim(s) name and contact information {Tarasoff Warning Details):

Acts of Property Damage? [ ]  Yes [ ]  No Most Recent Date:

Gravely Disabled? [ ]  Yes [ ]  No

\*Current Domestic Violence: [ ]  No [ ] Yes

Describe situation:

Child/Adult Protective Services Notification Indicated? [ ]  No [ ] Yes

Reported to:       Date:

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

\*Substance Use? [ ]  No [ ]  Yes [ ]  Client Declined to Report

If Yes, complete table below. *(refer to substance use table in instructions)*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Drug** | **Priority** | **Method of Admin-istration** | **Age 1st used** | **Freq-uency of Use** | **Days of use in last 30 days** | **Date of last use** | **Amount of last use** | **Amount used on a typical Day** | **Largest Amount Used in One Day** |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
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Urine Drug Screen: [ ]  Positive [ ]  Negative [ ]  Pending [ ]  Refused [ ]  N/A

Breathalyzer: [ ]  Positive [ ]  Negative [ ]  Pending [ ]  Refused [ ]  N/A

Comments Regarding Factors Increasing Risk:

Justice System Involvement? [ ]  Yes [ ]  No [ ] Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:

**OUTCOME/DISPOSITION**

Insurance [ ]  No [ ]  Yes

 [ ]  MediCal

 [ ]  Medicare

 [ ]  Other Insurance

\*Referred to: [ ]  ACL, 211. Or Other Community Support [ ]  Act Program [ ]  ADS [ ]  CAC [ ]  CAPS [ ]  Case Management Program [ ]  Clubhouse [ ]  CSU [ ]  ESU [ ]  FFS Hospital [ ]  FFS Individual Provider [ ]  FQHC [ ]  Hospital/ER [ ]  Jail [ ]  Juvenile Hall [ ]  Managed Care Plan – MH Provider [ ]  Managed Care Plan – PCP [ ]  Mental Health Res Treatment Facility [ ]  No Referral [ ]  OP Clinic [ ]  Other [ ]  Other Community Services [ ]  PEI Program [ ]  Regional Center Services [ ]  SDCPH [ ]  Specialty Mental Health Services [ ]  START (Crisis House) [ ]  Substance Abuse Treatment - OP [ ]  Substance Abuse Treatment – Residential [ ]  TBS [ ]  WIAC/JWC [ ]  Withdrawal Management

Referrals

 Name

 Address

 City/State/ZIP

 Phone

 Person to Contact

 Directions or Other Instructions

Referrals

 Name

 Address

 City/State/ZIP

 Phone

 Person to Contact

 Directions or Other Instructions

Referrals

 Name

 Address

 City/State/ZIP

 Phone

 Person to Contact

 Directions or Other Instructions

Describe Outcome, Including Plan:

**Signature of Staff Completing Screening:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Time

Printed Name:       CCBH ID number: