**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-ted  Y or N | Dosage/  Frequency | Amt. Prescribed | Target  Sxs | 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: