**County of San Diego Mental Health Services**

**PERT 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 Client’s Age Today:       Date of Birth:

\*Is client on Conservatorship? [ ]  Yes [ ]  No [ ]  Unable to Assess

\*Does Client have Regional Center involvement? [ ]  Yes [ ]  No [ ]  Unable to Assess

\*Does client have CWS involvement? [ ]  Yes [ ]  No [ ]  Unable to Assess

Region service provided in: [ ]  Central [ ]  North Central [ ]  East

 [ ]  South [ ]  North Inland [ ]  North Coastal

**\*PRESENTING PROBLEM:** *(A summary of your clinical assessment. It should include: how you became involved with client, scene overview, client report, 3rd party report, justify 5150 or lack thereof):*

This PERT contact is related to which of the following:

[ ]  Mental Health

[ ]  Substance Use

[ ]  Co-Occurring

Is client currently taking medications (prescribed or over the counter): [ ] Yes [ ]  No [ ]  Unknown

Current and History of Mental Health Treatment *(check all boxes that apply)*: [ ]  Outpatient [ ]  Inpatient [ ]  Psychiatric Medications

**SCHOOL INFORMATION:**

Is client currently in school? [ ]  Yes [ ]  No [ ]  Refused/Unable to Assess

Current School:

If Other:

Current Grade Level:

Does client have an IEP or 504 Plan? [ ]  Yes [ ]  No [ ]  Unable to Assess

Educationally Related Mental Health Services? [ ]  Yes [ ]  No [ ]  Unable to Assess

History of behavioral problems in school? [ ]  Yes [ ]  No [ ]  Unable to Assess

Does client have a history of truancy, [ ]  Yes [ ]  No [ ]  Unable to Assess

suspensions or expulsions?

History of bullying? [ ]  Yes [ ]  No [ ]  Unable to Assess

History of being bullied? [ ]  Yes [ ]  No [ ]  Unable to Assess

Victim of violence/abuse? [ ]  Yes [ ]  No [ ]  Unable to Assess

Has a preoccupation with violence? [ ]  Yes [ ]  No [ ]  Unable to Assess

Violent drawings/writings? [ ]  Yes [ ]  No [ ]  Unable to Assess

Media research on explosives, weapons,

terrorist sites, school shootings? [ ]  Yes [ ]  No [ ]  Unable to Assess

Has intended victims? [ ]  Yes [ ]  No [ ]  Unable to Assess

Stalking behavior? [ ]  Yes [ ]  No [ ]  Unable to Assess

School violence plan? [ ]  Yes [ ]  No [ ]  Unable to Assess

If any yes answers above explain:

**POTENTIAL FOR HARM/RISK ASSESSMENT TAB**

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

\*Specify plan intent and ability to carry out the plan:

\*Previous Attempts or past suicidal behaviors? [ ]  Yes [ ]  No [ ] Unknown/Refused

\*Describe:

\*Has the client had suicidal ideation in the past 12 months? [ ]  Yes [ ]  No

[ ] Unknown/Refused

\*Explain:

\*Are the client’s current/recent behaviors possibly creating a danger to self (things to consider: non-suicidal self-injurious behavior, method, severity, frequency, remote vs ongoing)?

[ ]  Yes [ ]  No [ ] Unknown/Refused

Explain:

\*Access to weapons/explosives? [ ]  Yes [ ]  No [ ] Unknown/Refused

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

\*Specify plan, intent and ability to carry out the plan:

\*Has the client had violent/homicidal ideation towards others in the past 12 months?

[ ]  Yes [ ]  No [ ] Unknown/Refused

\*Explain:

\*Does the client have past behavior of violence (Things to consider: toward property or animals, toward people, domestic violence, anti-social, intimidation, predatory, restraining orders?

[ ]  Yes [ ]  No [ ] Unknown/Refused

\*Describe:

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

Reported To:       Date:

\*Victim(s) name and contact information *(Give victim information, time/date, and method of notifying the victim. Provide the Tarasoff warning details):*

\*Is the client’s Current/recent behavior possibly creating a danger to others? [ ]  Yes [ ]  No [ ] Unknown/Refused

 \*Describe:

\*Gravely Disabled? [ ]  Yes [ ]  No [ ]  Unknown/Refused to answer

*(Explain why client did or did not meet criteria. Be very specific and clear. Gravely disabled is the inability to procure and/or utilize food, clothing, and/or shelter due to mental illness).*

\*Describe:

\*Current Abuse or Domestic Violence: [ ]  Yes [ ]  No [ ] Unknown/Refused

\*Describe situation:

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

Reported to:       Date:

\*Recent Substance Use? [ ]  No [ ]  Yes [ ]  Unknown/Refused to answer

 \*Describe:

\*History of substance use or treatment for substance use? [ ]  No [ ]  Yes [ ]  Unknown/Refused to answer

 \*Describe:

\*Justice System Involvement? *(Add details when you have them. Avoid using police codes: ex 290, 245, etc.)*

 [ ]  Yes [ ]  No [ ] Unknown

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

**OUTCOME/DISPOSITION TAB**

\*Insurance: [ ]  No [ ]  Yes

(If Yes, check all that apply)

 [ ]  Medi-Cal

 [ ]  Medi-Care

 [ ]  Private Insurance/VA/Tricare

Describe Factors Increasing Risk (What are the barriers to client being successful in the community, why is PERT being utilized?):

Describe Protective Factors:

Safety Plan:

Disposition Level:

 [ ]  Emergency

 [ ]  Urgent

 [ ]  Non-Urgent

Emergency = 5150, voluntary hospitalization

Urgent = Transports to crisis residentials (includes withdrawal management, etc.), urgent walk-in centers or MH or SUD outpatient clinics

Non-Urgent = Review of protective factors & BHS resources, linkage

\*Referred to: *Check all that apply*

[ ]  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

If Other, specify:

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

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Describe Outcome, Including Plan *(What criteria did the client meet? Referrals offered, include if client refused the referrals. Tarasoff details)*:

**CARE COORDINATION:**

Which or the following providers were contacted by the PERT Clinician? (check all that apply):

**[ ]** Outpatient Treatment Provider [ ]  Psychiatrist [ ]  School Representative

[ ]  Probation Officer [ ]  CWS Worker [ ]  APS worker [ ]  Regional Center

[ ]  LECC/Other LE agencies [ ]  Conservator’s Office [ ]  Other

[ ]  Not Applicable

For any item indicated, provide documentation as to the nature of the contact or why not applicable:

**Signature of Staff Completing Screening:**

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

Signature Date Time

Printed Name:       CCBH ID number: