Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**
Date of Referral:		

Reason for Referral and Chief Complaint/Presenting Problem

Reason for Referral and Chief Complaint/presenting problem-priority and/or emergency issues in individual's own words:

Family/Guardian description of problem (if relevant):

History of Present Psychiatric Illness (Describe course of presenting stressors/symptoms/concerns):

Past Psychiatric History (Previous episodes of current symptoms and any other past psychiatric concerns):

Substance Use/Addictive Behavior Screen

Does individual report problems (historical or current) with any of the following?

☐ Illegal drug ☐ Prescription drug ☐ Non-prescription (OTC) ☐ Alcohol ☐ Gambling ☐ Tobacco ☐ None Reported

Mental Health Treatment History ☐
Addiction Treatment Service History ☐

Treatment Services History Within the Past 5 years ☐ **None Reported**

Type of Services	Dates of Service	Reason	Name of Provider/Agency:	Completed
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes

Comment further if additional episodes, as indicated:

What was helpful with past treatment?

What was not helpful?

Additional Comments:

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Past and Current Social and Developmental Status:

Developmental History (Include individual and family history, motor development and functioning, sensory, speech, hearing and language problems, previous diagnosis of developmental disability and any eligibility for Office of Persons with Developmental Disabilities (OPWDD) services):

Sexual History

Sexual History/Concerns (Include sexual orientation and other relevant information; OMH complete Communicable Disease Assessment as indicated**):** ☐ NA – Based upon the Individual's age and needs

Vocation/Education/Employment

Highest Grade Completed

☐ *No formal education*
☐ *Pre-K*
☐ *Kindergarten*
☐ *1st*
☐ *2nd*
☐ *3rd*
☐ *4th*
☐ *5th*
☐ *6th*
☐ *7th*
☐ *8th*
☐ *9th*
☐ *10th*
☐ *11th*
☐ *12th, no diploma*
☐ *High School Diploma*
☐ *General Equivalency Diploma*
☐ *Vocational Cert w/o Diploma/GED*
☐ *Vocational Cert w/ Diploma/GED*
☐ *Some College – No degree*
☐ *Associates Degree*
☐ *Bachelors Degree*
☐ *Graduate Degree*

Employment Status (Select First that applies)

☐ Competitive and integrated employment
☐ Other Employment
☐ Non-paid work position (volunteer)
☐ Unemployed and looking for work
☐ **Not in Labor Force**: unemployed but not looking for work, retired, homemaker, student, incarcerated or psychiatric inpatient

Employment History ☐ NA

Type of Job	How Long	Reason for Leaving
	_____**Months /** _____ **Years**	
	_____**Months /** _____ **Years**	
	_____**Months /** _____ **Years**	
	_____**Months /** _____ **Years**	

Approximate Literacy Level *(Required for CARF-see Manual) and impact on treatment, if any:*

Children and Adolescents

Name of School:	***Current Grade:***

Regular Education Classroom (*No Special Services****):*** ☐ *No* ☐ *Yes - If no, check all that apply below.*

Educational Classification

☐ *Autism*
☐ *Deafness*
☐ *Deaf-Blindness*
☐ *Emotional Disturbance*
☐ *Hearing Impairment*
☐ *Intellectual disability*
☐ *Learning disability*
☐ *Multiple disabilities*
☐ *Orthopedic Impairment*
☐ *Other Health Impairment*
☐ *Speech or language Impairment*
☐ *Traumatic Brain Injury*
☐ *Visual Impairment*

Additional Information, if indicated:

Current IEP: ☐ *No* ☐ *Yes*
Current 504 Plan: ☐ *No* ☐ *Yes*

☐ *Home Schooled*
☐ *Gifted*

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Comments on Past and Current Academic Functioning (*include grades, learning ability, learning style and any other relevant indicators****):***

Test or Other Evaluation Results *(IQ; achievement; developmental; PT/OT; etc.)* ☐ *No Test Results Reported*

Attendance: ☐ *Not a Problem*

Previous Grade Retentions: ☐ *Denied*

Suspensions/Expulsions: ☐ *Denied*

Additional Barriers to Learning:

Peer Relationship/Social Functioning:

Vocation/Education/Employment Screen/Summary *(For Children/Adolescents and Adults)*

Does the individual want help with or desire further discussion of the following? If yes to any area below, comment on history, strengths, weaknesses and aspirations (required for COA):

Vocational ☐ No ☐ Yes - Comment:

Educational ☐ No ☐ Yes - Comment:

Employment ☐ No ☐ Yes - Comment:

Military Service Screen

Has the individual ever served in the military? ☐ No ☐ Yes - If yes, Comment:

If yes, is the individual currently experiencing:

☐ Physical health concerns as a result of military experience?
☐ Pain right now or have experienced chronic pain? ☐ Frequent nausea, stomach upset, and/or deliriums?
☐ Concerns of possible infectious agents, toxins, or radiological exposure?
☐ Psychological Issues related to military service (Flashbacks, Nightmares, etc.)

☐ **Individual has concerns that seeking help may impact his/her career.**

Comments:

Further assessment with the Military Service Assessment can be done *at any point during care.*

Is there someone in the family, or a significant other, in the military? ☐ No ☐ Yes - If yes, Comment:

If yes, further assessment with the Military Service Assessment for Significant Others can be done *at any point during care.*

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

LEGAL INVOLVEMENT HISTORY ☐ None Reported

Does the individual have a history of, or current, involvement with the legal system (i.e., legal charges, AOT, Specialized Courts-Drug, Mental Health, Family, Arrests, Incarceration, etc.)? ☐ No ☐ Yes
Is there a family history of, or current involvement with CPS? ☐ No ☐ Yes / APS? ☐ No ☐ Yes
If yes to either of the above, complete and attach the Legal Involvement and History Addendum.

Legal Status

Does Individual Served have a Legal Guardian, Rep Payee or Conservatorship? ☐ No ☐ Yes
Is there a Special Needs Trust other than parent? ☐ No ☐ Yes
If yes to either question above, complete and attach the Legal Status Addendum

Is there a need for a Legal Guardian, Rep Payee, Conservatorship or Special Needs trust? ☐ No ☐ Yes
If Yes, explain:

Does the individual have any advance directives? ☐ No ☐ Yes
If Yes, what type? ☐ DNR ☐ Health Care Proxy ☐ Living Will ☐ Psychiatric Advance Directive

Living Situation (Reference Personal Information Form)

Household composition and any housing needs:

Family History and Relationships

Comment on family/significant other relationships as applicable (Describe past and current relationships with family/significant others):

Family History of Relevant Health (including Developmental Disabilities), Mental Health, and Addiction concerns:

Custody Issues: ☐ **NA OR:**
Describe custody arrangement/parenting plan as it relates to individual/comments:

Trauma History

Does individual report a history, or current experience, of:

Select all that are reported:

☐ Physical Abuse/Neglect ☐ Elder Abuse ☐ Community Violence ☐ Verbal/Emotional Abuse ☐ Sexual Abuse/Molestation
☐ Immigration Trauma ☐ Witness to Violence ☐ Domestic Violence
☐ Other:
☐ None Reported

Provide Relevant Details and Current Clinical Impact:

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Social/Leisure Supports/Concerns

Friendships/Social/Pets/Peer Support Relationships:

Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests):

Community Supports/Self Help Groups (AA, NA, NAMI, Double Trouble, Peer Support, Meals-on-Wheels, etc.):

Religion/Spirituality (Discuss protective and/or risk aspects):

Cultural/Ethnic Information (Discuss protective or risk aspects):

Functional Assessment

Comment on daily living skills and ability for self care (including financial needs):

Other functional impairments:

Physical Health History

☐ **Refer to Brief Medical Screening Form** *(includes past and current Medication information)* **dated:**
☐ **Additional Comments, if indicated:**

Suicide and Violence Risk

Suicide and Self-Harm Screen/Assessment

Sources of Information

☐ Columbia-Suicide Severity Rating Scale (C-SSRS)	☐ Clinical Interview	☐ Clinical records
☐ Other approach or evidence based tool (i.e. Chronological Assessment of Suicide Events (CASE) Approach	☐ Collateral sources	

Suicidal ideation (history/current): No Yes – If Yes, provide details:

Suicidal planning (history/current): ☐ No ☐ Yes - If Yes, provide details:

History of suicidal behaviors? ☐ No ☐ Yes - If Yes, provide details:

History of self-injurious behavior (i.e. cutting, burning)? ☐ No ☐ Yes - If Yes, specify and note safety management plan below:

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Is there evidence of suicide risk? ☐ No ☐ Yes – If Yes:

Does the individual have access to lethal means/weapons? ☐ No ☐ Yes - If Yes, provide details:

Describe discussion with individual/family to secure access to lethal means/weapons.

Identify and discuss impact of significant risk and protective/mitigating factors:

Safety Management Plan: Describe in detail how elements of risk will be managed, including any risk for non-suicidal self-injurious behavior:

Violence Screen/Assessment

Sources of Information -

☐ Evidenced-based screening/assessment tool(s)
- If Yes, specify:

☐ Clinical Interview

☐ Collateral sources

☐ Clinical records

Recent thought/intention or actual plan to hurt others? ☐ No ☐ Yes - If Yes, provide details:

History of threatening/attempting or actually hurting others? ☐ No ☐ Yes - If Yes, provide details:

Current and/or recent thoughts or behaviors that others might interpret as threatening? ☐ No ☐ Yes - If Yes, provide details:

Other areas of concern including those from previous sections? ☐ No ☐ Yes - If Yes, note below as relevant to risk factors.

Is there evidence of violence risk? ☐ No ☐ Yes - If Yes:

Does the individual have access to lethal means/weapons? ☐ No ☐ Yes – If Yes, provide details:

Describe discussion with individual/family to secure access to lethal means/weapons.

Identify and discuss impact of significant risk and protective/mitigating factors:

Safety Management Plan: Describe in detail how elements of risk will be managed and/or how continued assessment will be conducted:

Life Goals, Strengths, Abilities, and Barriers

Life Goals:

Strengths (skills, talents, interests, protective factors):

Barriers (environmental and personal):

Past and Present Successes in Achieving Desired Goals:

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Service Preferences: describe individual/family/guardian/significant other perception of needs and preferences for health care and behavioral health services, including family participation in care and environmental supports (self-help, advocacy and empowerment activities):

Summary and Functional Eligibility

Summary: What are the need areas and determination of the recipient's functional eligibility for services? (discuss the factors that led to the needs, and the skills and resources needed to address them. Comment on desire and motivation to learn, and ability/capacity to respond to services. Base summary on full Assessment which includes Referral Information, Personal Information Form and additional assessments/addendums completed (i.e. Brief Medical Screening; Communicable Disease; Substance Abuse; Legal, etc.).

Diagnosis: ☐ DSM Codes ☐ ICD Codes
From Referral Information Record/Date:

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			
☐			
☐	Axis II		
☐			
	Axis III		

Axis IV	☐ No ☐ Yes	Problems with primary support group: If Yes, describe:	
	☐ No ☐ Yes	Problems related to the social environment: If Yes, describe:	
	☐ No ☐ Yes	Educational problems: If Yes, describe:	
	☐ No ☐ Yes	Occupational problems: If Yes, describe:	
	☐ No ☐ Yes	Housing problems: If Yes, describe:	
	☐ No ☐ Yes	Economic problems: If Yes, describe:	
	☐ No ☐ Yes	Problems with access to health care services: If Yes, describe:	
	☐ No ☐ Yes	Problems with interaction with the legal system/crime: If Yes, describe:	
	☐ No ☐ Yes	Other psychosocial and environmental problems: If Yes, describe:	
Axis V	Current GAF:		Highest GAF in Past Year (if known):

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Further Evaluations Needed:

☐ None Indicated ☐ Psychiatric ☐ Psychological ☐ Neurological ☐ Medical ☐ Educational
☐ Employment ☐ Visual ☐ Auditory ☐ Nutritional ☐ Other:

Prioritized Assessed Needs:	**A**-Active, **IFD**-Individual or Family/Guardian Declined, **D**-Deferred, **N/A**-Not Applicable, **R**-Referred Out				
	A	**IFD***	**D***	**NA***	**R***
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐
9.	☐	☐	☐	☐	☐

***Individual Declined/Deferred/Referred Out-Rationale(s)** *(Explain why the Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out/NA; Offer time frame for deferment below).* ☐ None

1.

2.

3.

4.

5.

6.

7.

8.

Individual Served/Guardian/Family Response to Recommendations (if family did not participate explain why):

Organization Name:	**Program Name:**	**Date:**
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Individual Served Signature (Optional):	**Date:**
Guardian Signature (Optional):	**Date:**

Completed By - Print Name/Credentials:	**Staff Signature:**	**Date:**
Team Leader/Clinical Supervisor - Print Name/Credentials (if needed):	**Team Leader/Clinical Supervisor Signature** (if needed):	**Date:**

For programs using this as a billable note, fill out Billing Strip below.

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes