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

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

Was any evidenced-based screening tool(s) used?: ☐ No ☐ Yes - If Yes, specify:

If yes to any, and required for OASAS, complete Substance Use/Addictive Behavior Assessment.
(OASAS Programs must also have individual complete Communicable Disease Risk Assessment)

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:**

OASAS ONLY

Number of prior substance /alcohol abuse treatment episodes, lifetime (Enter 0 – 5):

Has the individual ever been diagnosed with Mental Retardation/Developmental Disability	☐ No	☐ Yes
Co-existing Psychiatric disorder	☐ No	☐ Yes
Ever Treated for a mental illness problem	☐ No	☐ Yes
Ever Hospitalized for mental illness	☐ No	☐ Yes
Ever Hospitalized for 30 or more days for mental illness	☐ No	☐ Yes

Six Months Prior to Admission:
Number Days in Inpatient Detox: Number of Emergency Room Episodes:
Number of Days Hospitalized for Non-Detox Services:
Reason for Hospitalization: ☐ Medical ☐ Psychiatric ☐ Both

Brief Mental Health Screening

Was any evidenced-based screening tool(s) for mental health used?: ☐ No ☐ Yes - If Yes, specify:

Describe results:

Based on tool(s) and/or psychiatric information, Mental Health Screening indicates immediate mental health services needed.
☐ No ☐ Yes - If Yes, specify needs:

Past and Current Social and Developmental Status:

Developmental History (Include individual and family history, motor development and functioning, sensory, speech, hearing and language problems):

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 (OMH Only)*
☐ *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*

OASAS Only

Employment Status (Check One)

☐ Employed FullTime-35+ hrs/wk
☐ Employed Part Time-<35 hrs/wk
☐ Employed in Sheltered Workshop
☐ Unemployed, In Treatment
☐ Unemployed, Looking for Work
☐ Unemployed, Not Looking for Work
☐ Not in Labor Force, Child Care
☐ Not in Labor Force, Disabled
☐ Not in Labor Force, In Training
☐ Not in Labor Force, Inmate
☐ Not in Labor Force, Retired
☐ Not in Labor Force, Student
☐ Not in Labor Force, Other
☐ Soc Srvcs Work Exp Program
☐ Soc Srvcs Determined, Not Employed/Able to Work
☐ Soc Srvcs Determined, Unable to Work, Mandated Treatment

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

OMH Only

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 OASAS/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*

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:

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

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 OASAS/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.*

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
If Child, 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

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

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:

OASAS Only

Is the individual a Child of a person with Alcoholism and/or a Child of a person with a Substance Abuse Disorder?
☐ No ☐ Both ☐ Child of a person with Alcoholism ☐ Child of a person with a Substance Abuse Disorder

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:

Social/Leisure Supports/Concerns

Friendships/Social/Pets/Peer Support Relationships:

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

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

(OASAS) Has the Individual attended 12 step or other self-help groups in the last 30 days? ☐ **No** ☐ **Yes**

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

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

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

OASAS & ACT

Assessment of daily living / community living skills and ability for self care (include strengths and weaknesses):

Physical Health History

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

Mental Status, 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 – If yes, specify:
☐ 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, provide details and note safety management plan below:

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.

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

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:

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

Mental Status Evaluation (Narrative Below) OR ☐ Refer to MENTAL STATUS ADDENDUM (Recommended for OASAS)

Mental Status Evaluation Date Conducted:
(Provide a thorough written narrative below covering the following areas: Appearance and Behavior; Mood and Affect; Speech; Thought Process; Thought Content; Suicidal/Homicidal ideation; Cognition (if impaired, do Folstein Mini-Mental Status Exam), Insight and Judgment):

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:

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):

For OMH IPRT Only

Rehabilitation aspirations and results of the Psychiatric Rehabilitation Readiness Determination Form, including score:

For OMH Part 599 (Clinic) and Part 587.11 (Children's Day Treatment)
List collaterals interviewed:

Clinical Formulation – Interpretative Summary

Interpretive Summary: What in your clinical judgment are the need areas, 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 treatment. Base summary on full Comprehensive Assessment which includes Personal Information Form and additional assessments/addendums completed (i.e. Brief Medical Screening; Communicable Disease; Substance Abuse; Legal, etc.):

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

Diagnosis: ☐ DSM Codes ☐ ICD Codes

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):

Further Evaluations Needed:

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

Prioritized Assessed Needs: ***OASAS providers must provide clinical conclusions on each of the Eight Functional Areas****:* *1 Chemical dependence/abuse; 2 Physical health; 3 Mental health; 4 Vocational/educational/employment; 5 Social/leisure; 6 Family, 7 Legal; 8 Problem Gambling*	**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.	☐	☐	☐	☐	☐

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

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.

OMH Disposition (Applicable for First Assessment Session):

☐ Continue Assessment
☐ Admit (If admitting today, use this as Admission Note; otherwise use appropriate Progress Note upon Date of Admission):

If continuing assessment or admitting describe Initial Plan for Services (If admitting today, provider may skip this section and initiate services by completing at least one goal with one objective on the IAP):

☐ Do Not Admit (Provide rationale and referrals made)

☐ Individual declined services:

☐ Other:

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:**
Clinical Supervisor/ Professional Staff/ QHP/Team Leader - Print Name/Credentials (if needed):	**Clinical Supervisor/ Professional Staff/ QHP/Team Leader Signature** (if needed):	**Date:**
Other - Print Name/Credentials (if needed):	**Other Signature** (if needed):	**Date:**
Psychiatrist-Print Name/Credentials (if needed):	**Psychiatrist 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