

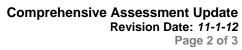






| | | Office of Ma | Improving Lives. | | | | rage 1013 | | | | |
|---|--------------------------------------|--------------|--|--------------------|--|--------|---------------|--|--|--|--|
| Organizati | ion Name: | | | Program Name: | | | Date: | | | | |
| Individual's Name (First MI Last): | | | | | Record #: | | DOB: | | | | |
| Reason f | or Update: | | of New Information | | Imission | Date (| of Admission: | | | | |
| | dditional/upo lated. | dated inforr | ection(s) of the assessmentation in your narrative v | ent (ir vith th | ent Sections for Update ncluding addendums), which he number of the section of | | | | | | |
| ☐ 1. | Reason for | | - | 11 | . Trauma History | | | | | | |
| Complaint/Presenting Problem 2. Psychiatric Illness/Substance | | | | 7 12 | 2. Social/Leisure | | | | | | |
| | Use/Addicti | | | 12 | Ooda/Leisure | | | | | | |
| 3. | | | | | 13. Physical Health History | | | | | | |
| 4. | Social and | | ental Status [| | I. Mental Status, Suicide, V | | | | | | |
| <u> </u> | Sexual Hist | | | | 5. Life Goals, Strengths, Ab | | | | | | |
| <u> </u> | Vocation/Ed | | mployment [| | Diagnosis (Case Manage | | t Only) | | | | |
| 7. | Military Ser | vice | | | Prioritized Assessed Nee | ds | | | | | |
| 8. | Legal | | | | 3. Other: | | | | | | |
| 9. | Living Situa | | | | O. Other: | | | | | | |
| | 10. Family History and Relationships | | | |). Other: | | | | | | |
| Update N | larrative: Li | st each ass | sessment section being u | updat | ed with narrative explanatio | n bel | low it. | | | | |
| | | | SCREE | NING | S TOOLS | | | | | | |
| Was any e | | d screening | tool(s), for either mental he | alth o | r substance use, utilized?: ☐ N | No [|] Yes | | | | |
| Diagnosis: ☐ No Change ☐ Change in Diagnosis: ☐ DSM Codes ☐ ICD Codes | | | | Liste | ed below | | | | | | |
| Check Primary | Axis | Code | | | Narrative Description | | | | | | |
| | Axis I | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | Axis II | | | | | | | | | | |
| | | | | | | | | | | | |
| | Axis III | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | Axis IV | □ No □ | Yes Problems with pri | mary | support group: | | | | | | |

If yes, describe:









| Organizati | ion Name: | | Pro | ogram Name: | Date: | | | | | | | | |
|---|--------------------|--------------------|---|---------------------------------|------------------|-----|----|----|--|--|--|--|--|
| Individual | 's Name (Firs | t MI Last): | · | Record #: | DOB: | | | | | | | | |
| | | ☐ No ☐ Yes | Problems related to the If yes, describe: | e social environment: | | | | | | | | | |
| | | □ No □ Yes | Educational problems: If yes, describe: | | | | | | | | | | |
| | | □ No □ Yes | Occupational problems If yes, describe: | s: | | | | | | | | | |
| | | □ No □ Yes | Housing problems: If yes, describe: | | | | | | | | | | |
| | | □ No □ Yes | Economic problems: If yes, describe: | | | | | | | | | | |
| | | □ No □ Yes | | to health care services: | | | | | | | | | |
| | | □ No □ Yes | | ion with the legal system/crime | : | | | | | | | | |
| | | □ No □ Yes | | d environmental problems: | | | | | | | | | |
| | Axis V | Current GAF: | ŀ | Highest GAF in Past Year (if kn | iown): | | | | | | | | |
| 4 Comit | na Duafavan | | d /Family/Guardian E | Expression of Service Pre | ference | es | | | | | | | |
| 1. Service Preferences: | | | | | | | | | | | | | |
| Tre | | | | No Additional Recommend | | | | | | | | | |
| | 7,7,10,110,110,110 | | | , acom.oa acio.i.oa io | A | ID* | D* | R* | | | | | |
| 1. | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | |
| *Individual Declined/Deferred/Referred Retionals(s) (Evalois why Individual Declined to work on Need Associated | | | | | | | | | | | | | |
| *Individual Declined/Deferred/Referred Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred or Referred Out below). 1. | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | |
| Further Eva | luations Need | ed: None Indicated | i | | | | | | | | | | |
| ☐ Psychiat | tric | - | eurological | | cational her: | | | | | | | | |
| Level of Care/ Indicated Services Recommendation: | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Individual Served/Guardian/Family Response to Recommendations: | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |









Organization Name: Program Name: Date: Individual's Name (First MI Last): Record #: DOB: Treatment Planning Updates Change In IAP Required:
No Yes (If Yes, complete the IAP Revision/Review Form to record needed changes in Goal(s), Objective(s), Interventions, Services, Frequency, and/or Provider type) Date: Individual Signature (Optional): Date: Guardian Signature (Optional): Completed By - Print Name/Credentials: Staff Signature: Date: Clinical Supervisor/ Professional Staff/ QHP/Team Clinical Supervisor/ Professional Staff/ Leader - Print Name/Credentials (if needed): QHP/Team Leader - Print Name/Credentials Date: (if needed): Other - Print Name/Credentials (if needed): Other Signature (if needed): Date: Psychiatrist-Print Name/Credentials (if needed): Psychiatrist Signature (if needed): Date