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

Present at Session: ☐ Individual Present / If others present, please list name(s) and relationship(s) to individual:

Comprehensive Assessment has been completed? Yes ☐ No ☐ If yes: Date of most recent assessment:

Reason for Referral and Chief Complaint

Reason for Referral and Chief Complaint in individual's own words:

Family/Guardian description of problem (if relevant):

History of Present Psychiatric Illness:

Past Psychiatric History ☐ **No** ☐ **Yes, If yes, Comment on past treatment and medication trials/effectiveness/side effects:**

Substance Use / Addictive Behavior History:

Organization Name:	**Program Name:**	**Date:**
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Past and Current Social and Developmental Status:

Developmental History:

Other (Sexual History, Vocation/Education, Employment, Military, Legal, Living Situation as indicated):

Family History and Relationships

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

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

Other (Religion/Spirituality; Cultural/Ethnic as indicated):

Physical Health History

NOTE: Refer to Brief Medical Screening, if completed:
Refer to Communicable Disease Assessment, if completed:

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:

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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.

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:**
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Mental Status Evaluation OR ☐ Refer to Mental Status Addendum

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):

Information from other sources (family, significant other, referring agency, etc.), including reports of diagnostic tests/exams and consultations. If child/adolescent, include information on past cognitive and achievement testing: ☐ None Reported

Clinical Formulation – Interpretative Summary

Diagnosis: ☐ DSM Codes ☐ ICD Codes

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			
☐			
☐	Axis II		
☐			
	Axis III		
	Axis IV	Problems with primary support group:	☐No ☐Yes
		Problems related to the social environment:	☐No ☐Yes
		Educational problems:	☐No ☐Yes
		Occupational problems:	☐No ☐Yes
		Housing problems:	☐No ☐Yes
		Economic problems:	☐No ☐Yes

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

		Problems with access to health care services: ☐No ☐Yes	
		Problems with interaction with the legal system/crime: ☐No ☐Yes	
		Other psychosocial and environmental problems: ☐No ☐Yes	
	Axis V	Current GAF:	Highest GAF in Past Year (if known):

Does individual have any medical conditions that require consideration in prescribing (i.e. pregnancy, diabetes, etc.)?
☐ Yes ☐ None reported or known If yes, specify:

Medications – Please fill out Medication List of all medications individual is taking including those prescribed by this provider, medications prescribed by outside prescribers as well as herbal remedies, vitamins, nutraceuticals, or over-the-counter drugs.

Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks/precautions, benefits, effectiveness (if applicable) and alternative treatment with the individual (parent/guardian): ☐ No ☐ Yes

Are there any barriers/limitations to individual's medication management/self administration?: ☐ No ☐ Yes -If Yes:

1. **Disorganization:**
2. **Cognitive Limitation:**
3. **Limited Insight:**
4. **History of Non-Adherence:**
4. **Difficulty with Follow through:**
5. **Other:**

Individual	☐ Understands information	☐ Does not understand	☐ Agrees To Take Medication	☐ Refuses Medication
Guardian	☐ Understands information	☐ Does not understand	☐ Agrees To Take Medication	☐ Refuses Medication

Individual's /Guardian's Response: ☐ N/A

Recommendations: (Include all medical strategies, session frequency, labs, referrals, next visit):

1.

2.

3.

4.

Prioritized Assessed Needs: A-Active, ID-Individual Declined, F/G-Family/Guardian declined, D-Deferred, R-Referred Out	**A**	**ID***	**F/G***	**D***	**R***
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐

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

4.	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐

***Individual Declined/Deferred/Referred Out-Provide Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred/Referred Out below).** ☐ None

1.

2.

3.

Other Psychopharmacological Considerations to be added to Individualized Action Plan:
☐ None indicated at this time:

Individual's Signature (Optional)**:**	**Date:**
Guardian's Signature (Optional)**:**	**Date:**

Physician/NPP - Print Name/Credentials:	**Physician/NPP Signature:**	**Date:**
Supervisor - Print Name/Credentials (if applicable):	**Supervisor Signature** (if applicable):	**Date:**