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

Brief Interval History (Hospitalization, Suicide/Homicide Attempts/Gestures, Risk Factors, Changes in Clinical Status/Treatment, Adherence with Treatment, Medical Illnesses, etc.):

MENTAL STATUS EXAM OR ☐ Refer to Attached Mental Status Evaluation

Mental Status Evaluation (Provide a thorough written narrative below):

If providing a mental status narrative, also answer current risk related questions below:

Danger To: ☐ None Reported or Observed OR:

☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

Comments:

Reported side effects and other comments on current or past medication (Indicate Allergies/Adverse events on Medication List):

Diagnosis: ☐ No Change ☐ Change in Diagnoses Listed below
☐ DSM Codes ☐ ICD Codes

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			

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

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

Prioritized Assessed Needs: ☐ No Additional Recommendations Clinically Indicated A-Active, ID-Individual Declined, D-Deferred, F/G-Family/Guardian declined, R-Referred Out (If declined/deferred/referred out, please provide rationale)	**A**	**ID***	**FG***	**D***	**R***
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐

***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**).** ☐ None

1.

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**
2. **3.**		
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:**