| 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:**       |
| **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* |
| ***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.*** |
| **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 [ ]  YesIs 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 [ ]  YesIs 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:**       |
| **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:       |
| **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  | [ ]  Clinical records |
|  | [ ]  Collateral sources |  |
| 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**:       |
| **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):       |
| **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):        |
| 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 |
|       |       |       |       |     |     |     |     |       |       |       |