**Pre-Admission Screening Form**

Request for: Inpatient Crisis Residential Outpatient Request Crisis Intervention \_\_\_\_\_\_\_ Consult

Date \_\_\_\_\_\_\_\_\_\_\_ Time of Request:\_\_\_\_\_\_\_\_\_\_\_ Location Code:\_\_\_\_\_\_\_\_\_\_\_ Service Code:\_\_\_\_\_\_\_\_\_\_\_ Contact was: 🞎 Face to Face 🞎 Telephone

Face to Face Contact Start Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_am/pm Face to Face Contact End Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ am/pm Disposition Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Case #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: / / Age:\_\_\_\_\_\_ Social Security # - -

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_ Phone #** - -

**County of Residence**  **County of Liability**   **Race**   **Vet Status**

**🞎 Medicaid:** Health plan **\_\_\_\_\_\_\_\_ 🞎 Medicare 🞎 Private Insurance; Type \_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 No Insurance**

**Education: 🞎***Comp Less than H.S* **🞎***Comp. Spec. ed/ H.S./G.E.D.* **🞎***In school* **🞎***In training program* **🞎***In spec education* **🞎***Attending under grad* **🞎***College grad*

**Employment Status: 🞎***Employed full time* **🞎***Employed part-time* **🞎***Unemployed, looking for work* **🞎***Not in competitive work force* **🞎***Retired from work*

**🞎***Sheltered work shop* **🞎***In supported employment* **🞎***N/A*

**Corrections Status: 🞎***In prison* **🞎***In jail* **🞎***Probation from jail* **🞎***Juvenile Detention Center* **🞎***Court supervision* **🞎***Not under jurisdiction* **🞎***Awaiting trial*

**🞎***Awaiting sentencing* **🞎***Minor referred by Court* **🞎***Arrested and booked* **🞎***Diverted from arrest/booked* **🞎***Parole from prison* **🞎***N/A*

**Residential Living Arrangement: 🞎***Prison/Jail/Juvenile Det. Center* **🞎** *Supported Independence Program* **🞎** *Private residence w/parents* **🞎** *Private residence on own* **🞎***Foster family home***🞎***Specialized Residential Home***🞎***General Res. Home***🞎***Nursing Home***🞎***Homeless***🞎***Missing*

Guardian/Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian/Parent Phone#\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

Other Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other contact Phone #\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ ROI obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Place of Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CMH status: Open Case \_\_\_\_\_ Closed Case \_\_\_\_\_ Pending Case \_\_\_\_\_\_\_ New Case

### CMH CSM/Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Psychotropic Meds prescribed by:

### Current Meds and Dosage:

###

### Referral Source:🞎*Family* 🞎*Hospital* 🞎*Police* 🞎*Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

### Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assessment/ Precipitating Factors/ Intervention/Plan/Disposition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 \_\_\_\_\_\_\_

Substance Abuse History:

1. Alcohol Use: [ ] Yes [ ] No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Drug Use: [ ] Yes [ ] No Drug of choice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long?
3. When Last Used?
4. Substance Use Disorder Treatment: [ ] Yes [ ]  No When? Where?

Accommodation needs:

Preliminary Diagnosis: Primary: Secondary: Tertiary:

Quaternary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quinary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Senary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Septenary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems with: Primary Support Group/Social Environment/Education Occupation/Housing/Economic/Access to Health Care Services/Legal/Other:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 **Severity of Illness**

**1: Severe/serious 2: Moderate 3: Mild 4: Not applicable**

**(Instructions: Mark the number relating to the level of severity criteria the individual meets under each category.**

**Write supporting clinical documentation including symptoms, functional impairments and risk potential in the Clinical Documentation Section.**

|  |  |  |
| --- | --- | --- |
|   | Level of Severity  | Severity of Illness: Documentation |
| 1. Psychiatric Symptoms |  |   |
| 2. Disruption of Self Care Abilities |  |  |
| 3. Possibility of Harm to Self |  |  |
| 4. Possibility of Harm to Others |  |  |
| 5. Possibility of Medication/Drug Compliance or Regimen Complication |  |  |

**Intensity of Services Required/ Disposition:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Inpatient** | **Crisis Residential** | **Other Community Support**  | **Statement of Crisis Resolution** **Disposition/ Service Recommendation** |
| A. Continuous medical supervision and observation are necessary. | B. Requires highly structured supervised care. | C. Meets criteria for Crisis Bed.  |  |
| A. Continuous skilled medical observations needed due to unmanageable side effects of psychotropic medications. | B. Consistent Observation and supervision of behavior is needed. | C. Appropriate for MI Outpatient Services |  |
| A. Continuous observation and control of behavior is needed to protect individtual, others and/or property. | B. Individual has reached a level of clinical stability but continues to require a structured and supervised 24 hour program to consolidate progress.  | C. Appropriate for referral to other communty services.  |  |
| A. A comprehensive multimodel therapy plan is needed requiring close medical supervision and coordination. | B. Intensive monitoring of medication regimen and response is necessary.B. Individual needs to be temporarily separated from natural environment at risk of further deterioration of condition. B. A comprehensive, intensive program of treatments, services and supports is needed. |  |  |

Inpatient: [ ]  Formal Adult Voluntary [ ]  Involuntary Admission

**Crisis line number provided: \_\_\_\_\_ Referred elsewhere: \_\_\_\_\_\_ Where: SUD Treatment Referral:**

**Appeal rights explained/given: [ ] Yes [ ] No Client Initials\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Credentials Date:\_\_\_\_\_\_\_\_**

Cc: Original to Hospital Program Coordinator, then to chart

**For Administrative Use Only**

ACCESS WORKER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIME/DATE CALLED IN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SERVICES AUTHORIZED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AUTHORIZATION #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TRANFERRED TO NEXT CRISIS WORKER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELEASE OF INFORMATION ENTERED INTO OASIS: \_\_YES\_\_NO\_\_N/A

COORDINATION OF CARE \_\_YES\_\_NO\_\_N/A TREATMENT TEAM NOTIFIED \_\_YES \_\_NO\_\_N/A