**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 Person Phone #:       ROI obtained: [ ]  Yes [ ]  No

### 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?       When last used?
3. 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**  | **Disposition/ Service Recommendations** |
| 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 individual, 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 community 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

### Substance Abuse Referral:

### 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 Liaison, then to Chart.

|  |
| --- |
| **For Administrative Use Only****Access Worker:**       **Time/Date Called In:**      **Services Authorized:**       **Authorization #:**      **Transferred 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 |