



Organization Name:	Program Name:	Date:
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Individual's Name (First MI Last):	Record #:	DOB:
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Assessment/Referral Information Received Dated:

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/Other description of problem/need (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

If yes to any complete Substance Use/Addictive Behavior Assessment.

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
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes

Comment further if additional episodes, as indicated:

What was helpful with past treatment?

What was not helpful?



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Past and Current Social and Developmental Status:

Developmental History (Include individual and family history, motor development and functioning, sensory, speech, hearing and language problems):

Symptom Management Plan

Existing Relapse / Safety Plan Attached, No Update Required Or Complete:

What are the individual's early warning signs/triggers that things are too stressful, deteriorating, or not going well that could be a sign of relapse?

What actions can the individual take and what supports will the individual need to manage stress, stay well, and remain focused on goals?

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

- | | | |
|--|---|--|
| <input type="checkbox"/> No formal education | <input type="checkbox"/> 5th | <input type="checkbox"/> High School Diploma |
| <input type="checkbox"/> Pre-K | <input type="checkbox"/> 6th | <input type="checkbox"/> General Equivalency Diploma |
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> 7th | <input type="checkbox"/> Vocational Cert w/o Diploma/GED |
| <input type="checkbox"/> 1st | <input type="checkbox"/> 8th | <input type="checkbox"/> Vocational Cert w/ Diploma/GED |
| <input type="checkbox"/> 2nd | <input type="checkbox"/> 9th | <input type="checkbox"/> Some College – No degree |
| <input type="checkbox"/> 3rd | <input type="checkbox"/> 10th | <input type="checkbox"/> Associates Degree |
| <input type="checkbox"/> 4th | <input type="checkbox"/> 11th | <input type="checkbox"/> Bachelors Degree |
| | <input type="checkbox"/> 12th, no diploma | <input type="checkbox"/> Graduate Degree |

Employment Status (Select First that applies)

- | | |
|--|--|
| <input type="checkbox"/> Competitive and integrated employment | <input type="checkbox"/> Unemployed and looking for work |
| <input type="checkbox"/> Other Employment | <input type="checkbox"/> Not in Labor Force: unemployed but not looking for work, retired, homemaker, student, incarcerated or psychiatric inpatient |
| <input type="checkbox"/> Non-paid work position (volunteer) | |

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 involvement in this residential setting, if any:

Children and Adolescents

Name of School:	Current Grade:
Regular Education Classroom (No Special Services): <input type="checkbox"/> No <input type="checkbox"/> Yes - If no, check all that apply below.	
Educational Classification	



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<input type="checkbox"/> Autism <input type="checkbox"/> Deafness <input type="checkbox"/> Deaf-Blindness <input type="checkbox"/> Emotional Disturbance <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Learning disability		<input type="checkbox"/> Multiple disabilities <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Other Health Impairment <input type="checkbox"/> Speech or language Impairment <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Visual Impairment	Additional Information, if indicated: Current IEP: <input type="checkbox"/> No <input type="checkbox"/> Yes Current 504 Plan: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Home Schooled <input type="checkbox"/> 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.) <input type="checkbox"/> No Test Results Reported -			
Attendance: <input type="checkbox"/> Not a Problem -			
Previous Grade Retentions: <input type="checkbox"/> Denied -			
Suspensions/Expulsions: <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:			
Educational <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:			
Employment <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:			
Military Service Screen			
Has the individual ever served in the military? <input type="checkbox"/> No <input type="checkbox"/> Yes, - if yes, Comment:			
If yes, does the individual have any concerns related to military service that will impact involvement in a residential setting? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, Comment:			
Further assessment with the Military Service Assessment can be done at any point while in this residential setting.			
Is there someone in the family, or a significant other, in the military? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, Comment:			
If yes, further assessment with the Military Service Assessment for Significant Others can be done at any point while in this residential setting.			



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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 Yes
 Is 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 Yes
 If Child, is 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:

Describe past living situations and experiences including community residence/apartment program:

Prospective Housing Situation

What does the individual think about living in this residential setting?

What are the strengths (skills/personal resources that can be used in this residential setting)?

Are there any areas which might be challenging (i.e., expectations, responsibilities, staff supervision, living with someone who smokes, visiting/smoking/pet policies?)

Is the individual willing to share a bedroom? Ever shared a bedroom before?

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:



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Has a Doctor EVER told you that you had any of the following conditions?

<u>Condition</u>	Check One		Currently Under a Doctor's Care	Comment
	Now	Past		
Alzheimer's Disease or Dementia	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Sugar-High	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Pressure (High)	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Deafness or other hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	<input type="checkbox"/>	<input type="checkbox"/>		
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		
Hyperlipidemia (High blood fat/Cholesterol and/or Triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>		
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	<input type="checkbox"/>	<input type="checkbox"/>		
Mobility Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Other Cardiac Condition	<input type="checkbox"/>	<input type="checkbox"/>		
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	<input type="checkbox"/>	<input type="checkbox"/>		
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis*) - If Yes to any, complete Communicable Disease Risk Assessment	<input type="checkbox"/>	<input type="checkbox"/>		
Sight Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>		
Weight (Obesity, Unexplained Gain or Loss)	<input type="checkbox"/>	<input type="checkbox"/>		
Other physical related health conditions	<input type="checkbox"/>	<input type="checkbox"/>		

Joint Commission Only	<p>If Physical Examination was performed within 12 months prior to admission, have there been any changes in individual's physical health condition? <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe:</p> <hr/> <p>If Yes, does this information prompt a new physical examination referral? <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe any actions required:</p>
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Does the individual have any issues with self-preserving/evacuating during emergencies? No Yes, specify:



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Violence Screen/Assessment

Sources of Information -

- Evidenced-based screening/assessment tool(s)
 Clinical Interview
 Clinical records
 Approach – If yes, specify:
 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:



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Formulation – Interpretative Summary

Interpretive Summary: What in your clinical judgment are the need areas, the factors that led to the needs, and the skills and resources needed to address them? Include the needs indicated by the family/caregiver. Base summary on Referral Information and full Assessment which includes Personal Information Form and additional assessments/addendums completed (i.e. Communicable Disease; Substance Abuse; Legal, etc.).

Diagnosis: DSM Codes ICD Codes
From Referral Information Record/Date:

Check Primary	Axis	Code	Narrative Description
<input type="checkbox"/>	Axis I		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>	Axis II		
<input type="checkbox"/>			
<input type="checkbox"/>	Axis III		
<input type="checkbox"/>	Axis IV		
<input type="checkbox"/>			
Current GAF:		Highest GAF in Past Year (if known):	

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.	<input type="checkbox"/>				
2.	<input type="checkbox"/>				
3.	<input type="checkbox"/>				
4.	<input type="checkbox"/>				
5.	<input type="checkbox"/>				
6.	<input type="checkbox"/>				
7.	<input type="checkbox"/>				
8.	<input type="checkbox"/>				



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9.	<input type="checkbox"/>				
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***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.

Result of Intake Assessment

Individual Is Not Being Recommended for participation. Rationale for non-admission:

Individual Is Being Recommended for Participation (complete section below)

Recommended residential setting:

Recommended services (check all that apply):

Adult Services	
<input type="checkbox"/> Assertiveness/Self-Advocacy Training	<input type="checkbox"/> Rehabilitation Counseling
<input type="checkbox"/> Community Integration Services/Resource Development	<input type="checkbox"/> Skill Development Service
<input type="checkbox"/> Daily Living Skills Training	<input type="checkbox"/> Socialization
<input type="checkbox"/> Health Services	<input type="checkbox"/> Substance Abuse Services
<input type="checkbox"/> Medication Management and Training	<input type="checkbox"/> Symptom Management
<input type="checkbox"/> Parenting Training	<input type="checkbox"/> Other:

Children and Adolescent Services	
<input type="checkbox"/> Behavior Support	<input type="checkbox"/> Independent Living Skills Training
<input type="checkbox"/> Case Management	<input type="checkbox"/> Medication Management and Training
<input type="checkbox"/> Counseling Services	<input type="checkbox"/> Medication Monitoring
<input type="checkbox"/> Daily Living Skills Training	<input type="checkbox"/> Respite
<input type="checkbox"/> Educational-Vocational Support Services	<input type="checkbox"/> Socialization
<input type="checkbox"/> Family Support Services	<input type="checkbox"/> Other:
<input type="checkbox"/> Health Services	<input type="checkbox"/> Other:



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Additional Comments, if indicated:			
Individual Served/Guardian/Family Response to Recommendations (if family did not participate explain why):			
Individual Served Signature (if indicated):			Date:
Guardian's Signature (if indicated):			Date:
Completed By - Print Name/Credentials:	Signature:		Date:
Team Leader/Clinical Supervisor - Print Name/Credentials (if needed):	Team Leader/Clinical Supervisor Signature (if needed):		Date: