**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 |