COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

ADULT CARE COORDINATION AND RESIDENTIAL SERVICES

**Applicant Information**

Applicant Name:

Address:

City:       State:       Zip Code:

Home Phone:       Cell:

Email:

Date of Birth:       Social Security Number:

Driver’s License: [ ] Yes [ ]  No State:       Identification Number:

Legal Status: [ ] sex offender; if so, level \_\_\_ [ ] incarcerated [ ] restraining/order of protection [ ]  AOT

 [ ]  probation/parole; officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Information: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance:       Group #:

Secondary Insurance:       Group #:

Emergency Contact:       Phone:

Relationship:

**Applying for:**

[ ] Care Management/Coordination

**Please Choose Appropriate Level of Housing:**

[ ] Comprehensive Apartment Program - CAP (*apartment settings, staff visits 3x per week min. /daily visits maximum)*

*[ ] Hudson Community Apartments* *[ ] Columbia Street Apartments*

[ ] Supported Apartment SHUD (*apartment settings, staff visits 1-4x per month)*

[ ] 24-hr Supervised Community Residence:

[ ] High Cliff Terrace [ ] Philmont Hearth

Psychiatric History

Diagnostic Impression

Code:

Code:

Code:

Trauma History: [ ] sexual [ ] physical [ ] emotional [ ] domestic violence [ ] other

Use this space to provide details on age, frequency, duration, perpetrator, etc.

*Other Pertinent Psychiatric Information:*

To accompany my referral, **I have attached the following: psychosocial assessment AND physical health examination or other professional health evaluation** with relevant treatment information, completed within the past year.

I have reviewed this information and understand that this and other information will be given to the program(s) to which I am applying.

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

Applicant Signature Date

To be completed by the Referral Source

Referring Agency:

Contact:

Address:

City:       State:       Zip Code:

Phone:       Ext.       Fax:

Email:

Reason for Referral:

How long have you been working with the applicant?

To the best of your knowledge, what types of services will continue to be provided or have been requested for this individual?

[ ]  Therapy [ ] Psychiatry [ ] Adult Day/PROS [ ] Health Monitoring (WillCare)

[ ] Aging Services (Office for the Aging, Meals on Wheels)

How frequently?

Other Agencies Providing Support (name, type of service, contact information):

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

Referral Source Signature Date

COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

RELEASE OF INFORMATION

Applicant Name:       DOB:

I hereby authorize the following agencies to release and exchange the following information:

( ) Coordinated Entry/HUD Program

[ ] Capital District Psychiatric Center

[ ] Columbia Memorial Hospital

[ ] Greene Dept. of Social Srvs.

[ ] Greene County Mental Health Ctn

[ ] Greene County Probation

[ ] Mental Health Association

[ ] Office for People with Developmental Disabilities (OPWDD)

[ ] Twin County Recovery Services, Inc

[ ] WillCare

[ ] Other:

[ ] Other:

[ ] Current residential address and phone

[ ] Evaluation results

[ ] Employment records

[ ] Diagnosis, prognosis, treatment status

[ ] Discharge summaries

[ ] DSS assessments

[ ] DSS case type and grant amount

[ ] DSS case status

[ ] Medical records

[ ] Presence in treatment

[ ] Psychological/social assessments

[ ] Treatment plans

[ ] Other:

[ ] Other:

The purpose of this authorization is to assist with care management or residential housing services, or both, provide ongoing communication between the above agencies, fulfill court and DSS mandates, and coordinate care services. The information and/or documents obtained with this consent may be redisclosed only with my expressed written consent. I have read and understand the above and authorize the disclosure of such information as herein contained. I understand that this consent is subject to revocation at any time except to the extent that the person or agency, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon termination of services.

NOTE: CRIMINAL JUSTICE CONSENTS ARE IRREVOCABLE. THEY ARE VALID UNTIL THE DISPOSITION IN QUESTION HAS BEEN TERMINATED. THEREFORE, PROBATION CONSENTS MAY NOT BE REVOKED.

I also understand that any disclosure of the information and/or documentation is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information and/or documentation to a party other than the one(s) designated above is forbidden without additional written authorization on my part.

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

Signature Witness Date

Prescription for Residential Treatment

***For Residential Service Requests ONLY.***

AUTHORIZATION FOR RESTORITIVE SERVICES

COMMUNITY RESIDENCE PROGRAMS

Initial Authorization

Semi-Annual Authorization (CSR, CCR, HCT)

Annual Authorization (CAP)

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD.9 Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned licensed physician, based on my review of the assessment made available to me, have determined that the above named client would benefit from the provision of *Mental Health Restorative* services defined pursuant to *Part 593 of 14 NYCRR*. A copy of the most recent residential service plan review is attached.

*\*If this is an* ***Initial Authorization****, the prescribing physician must see the client face-to-face prior to authorizing services.*

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

Physician Signature Date

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

Printed Name and Title

COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

***To be completed by the Referral Source for Residential Admission***

Day Program Recommendation

*As this Residential Program maintains a rehabilitation focus, it is expected that all residents will engage in gainful activities during the weekday. This activity should be tailored to the individual, addressing his or her individual needs, strengths, goals, etc. Options for day activities include: attending PROS, school, Supported Employment, Supported Education, volunteer work, Sheltered Employment, or any other type of service program offered by COARC or a competitive employment placement. Our goal is to promote independence to the highest degree that the individual is able to attain. We value working collaboratively with the individual consumer, as well as with all collateral services providers in reaching this end.*

The recommended day activity for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This document will become part of the residential service plan.

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

Resident Primary Clinician

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

Program Director Date

COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

***FUNCTIONAL ASSESSMENT***

**To be completed by or with the applicant**

*Living arrangement at time of application:*

Independent

Family/Friends

Homeless

 Homebound

Community Residence (24 hr. Supervised)

Residential Program or Apartment

Does the applicant have a housing subsidy: Yes No Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please list all* ***living arrangements*** *starting with the most recent:*

|  |  |  |  |
| --- | --- | --- | --- |
| Description (location/with whom) | From | To | Outcome (Successful/Unsuccessful) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*Use this space to describe living situations other than above:*

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

*Activities of Daily Living*

*… please provide a general picture of* ***daily activities*** *or* ***schedule*** *of the applicant*

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

Will your schedule change if admitted into this program? Yes No

*Please describe how your schedule may change:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Personal Effectiveness |
| Please the check box to indicate issues within the **past** **30 days**: 1 = none or no issue 2 = minor 3 = moderate 4 = severe  | Severity |
| Arises promptly | 1 | 2 | 3 | 4 |
| Attends a day program |  |  |  |  |
| Demonstrates basic cooking skills |  |  |  |  |
| Keeps clinic or other appointments as scheduled |  |  |  |  |
| Maintain adequate personal hygiene |  |  |  |  |
| Maintains an adequate diet |  |  |  |  |
| Performs home maintenance, cleaning tasks |  |  |  |  |
| Smokes in a safe manner |  |  |  |  |
| Uses money correctly for purchases |  |  |  |  |
| Uses public transportation |  |  |  |  |
| Uses telephone correctly |  |  |  |  |
| Problem Solving and Interpersonal Skills |
| Please the check box to indicate issues within the **past 30 days**: 1 = none or no issue 2 = minor 3 = moderate 4 = severe | Severity |
| Acts assertively when appropriate | 1 | 2 | 3 | 4 |
| Apologize when appropriate |  |  |  |  |
| Exercise good judgment |  |  |  |  |
| Follow through on advice of doctor |  |  |  |  |
| Listen and understand |  |  |  |  |
| Obtain help for physical problems |  |  |  |  |
| Plan in cooperation with others |  |  |  |  |
| Resolve conflicts appropriately |  |  |  |  |
| Socialize with others |  |  |  |  |
| Take initiative or seek assistance with problems |  |  |  |  |
| Treat own minor physical problems |  |  |  |  |
| Other: |  |  |  |  |
| Functional Assessment |
| **Hygiene** | **Any additional Comments:** |
| Monitors on own |  |  |  |  |
| Needs assistance |  |  |  |  |
| **Shopping** |  |
| Shops independently |  |  |  |  |
| Needs assistance to shop |  |  |  |  |
| **Ability to maintain residence** |  |
| Manages on own |  |  |  |  |
| Needs assistance |  |  |  |  |
| **Economic Self Sufficiency** |  |
| Manages own money |  |  |  |  |
| Needs assistance |  |  |  |  |
| Has a representative payee |  |  |  |  |
| **Ability to Self-Direct Activities** |  |
| Can initiate plans |  |  |  |  |
| Can follow through with plans |  |  |  |  |
| Needs Assistance |  |  |  |  |

What do you expect to gain by working with this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your strengths and positive qualities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies and interests? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what areas of your life to you **want or need** to make changes?

|  |  |  |  |
| --- | --- | --- | --- |
| Educational |  | Transportation |  |
| Employment |  | Social/Recreational |  |
| Financial/Economical |  | Family |  |
| Housing |  | Legal/Probation |  |
| Medical Wellness |  | Other: |  |
| Mental Health Recovery |  |  |  |
| Self care |  |  |  |
| Substance Abuse |  |  |  |

What do you see as your role in making these changes?

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

What generally gets in your way of making changes in your life?

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

How do you think this service can assist you in making changes in your life?

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

Do you take your mental health medications as prescribed? Yes No

*I have answered the above questions to the best of my ability. I understand that this and other information contained in this referral will be presented at the next Care Management and Housing SPOA meeting to make a determination as to my eligibility and readiness for the services requested.*

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

Applicant Signature Date

COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

***FINANCIAL ASSESSMENT***

**Sources of Income**:

 Monthly Amount: If Pending….

SS Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSI Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Public Assistance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retirement benefits (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Worker's Compensation, unemployment ins. (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expenses:**

Child support

wage garnishment

fines/restitution

COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

***PSYCHIATRIC ASSESSMENT (To be completed if no psychosocial within the last year is attached)***

*Please list all* ***psychiatric inpatient admissions*** *starting with the most recent*

|  |  |  |  |
| --- | --- | --- | --- |
| Inpatient Provider | Admission | Discharge | Reason |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*Use this space to describe treatment related obstacles or outcomes of above:*

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

*Please list all* ***psychiatric outpatient admissions*** *starting with the most recent*

|  |  |  |  |
| --- | --- | --- | --- |
| Outpatient Provider | Admission | Discharge | Reason |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*Use this space to describe treatment related obstacles or outcomes of the above:*

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

History of suicide ideation (dates, methods, triggers): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Family/friend history of suicide attempts or completion (who, when, method): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What generally occurs when this person decompensates?

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

Is the person usually a danger to self or others when decompensating? Yes No

Does the person seek help when decompensating? Yes No

*Please explain:*

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

|  |
| --- |
| Psychiatric Symptoms Assessment |
| Please the check box to indicate issues occurring in the **past 30 days**: 1 = none or no issue 2 = minor 3 = moderate 4 = severe | Severity |
| Anxiety (worry, fear, over-concern for present or future | 1 | 2 | 3 | 4 |
| Blunted Affect (reduced emotional tone, reduction in normal intensity of feeling, flatness) |  |  |  |  |
| Disorientation (confusion or lack of association for person, place or time) |  |  |  |  |
| Emotional Withdrawal (lack of spontaneous interaction, isolation, deficit in relating to others |  |  |  |  |
| Excitement ( heightened emotional tone, agitation, increased reactivity) |  |  |  |  |
| Hallucinatory Behavior (perceptions without normal external stimuli) |  |  |  |  |
| Hostility (animosity, contempt, belligerence) |  |  |  |  |
| Mannerisms, posturing (bizarre motor behavior) |  |  |  |  |
| Motor Retardation (slowed, weakened movements or speech) |  |  |  |  |
| Somatic Concerns (preoccupation or fear of physical health and illness) |  |  |  |  |
| Suspiciousness (mistrust, believes others harbor malicious or discriminatory intent) |  |  |  |  |
| Tension (motor manifestations, nervousness, hyperactivity) |  |  |  |  |
| Uncooperativeness (resistance, guardedness, rejection of authority) |  |  |  |  |
| Unusual thought content or conceptual disorganization (odd, disorganized, bizarre or confused thoughts) |  |  |  |  |
| Risk Assessment |
| BEHAVIOR | YES | NO | Description (dates, injuries, legal status, etc) |
| Arson |  |  |  |
| Assaultive Behavior |  |  |  |
| Criminal Offenses |  |  |  |
| Medication Compliance |  |  |  |
| Sex Offender (status and level) |  |  |  |
| Driving/Traffic Violations |  |  |  |
| Other: |  |  |  |

*\*please note that positive responses to the above questions does not rule out admission to the program*

*Other Alerts:*

Presently at risk of psychiatric admission Yes No

Cycles in and out of the hospital with less than 90 days between admissions Yes No

History of long length of inpatient admissions (90 days +) Yes No

Frequent crisis related contacts Yes No

Reluctance to use traditional programs Yes No

Inadequate social support and/or difficulty in self monitoring Yes No

Current mental health services are deemed inadequate Yes No

Current suicidal ideations? Yes No

Current homicidal ideations? Yes No

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

Referral Source Signature Date

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

Physician’s Signature Date

Optional Physicians Notes:

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