CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES

First Name	Middle Initial	Last Name	Date of Birth	Individual's ID Number (Medicaid ID, Last 4 digits of SSN, other)

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following types of information.

- Behavioral and mental health services
- Referrals and treatment for an alcohol or substance abuse disorder

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information.

I. I consent to share my information among:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

II. I consent to share:

☐ All of my behavioral health and/or substance use disorder information

☐ All of my behavioral health and/or substance use disorder information except: (List types of health information you do not want to share below)

_____

I understand that HIPAA allows providers and other agencies to use and share much of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.

III. By signing this form I understand:

- I am giving consent to share my behavioral health and substance use disorder information. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- My information may be shared among each agency and person listed above.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits.
- My health information may be shared electronically.
- Other types of my information may be shared with my behavioral health and substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- The sharing of my health information will follow state and federal laws and regulations.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back.
- I should tell all agencies and people listed on this form when I withdraw my consent.
- I can have a copy of this form.
- My consent will expire on the following date, event or condition unless I withdraw my consent. (If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date.)

  Expiration Date: _____

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature of person giving consent or legal representative	Date

Relationship to individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

WITHDRAW OF CONSENT

I understand that any information already shared with or in reliance upon my consent cannot be taken back.

I withdraw my consent to the sharing of my health information:

☐ Between any of the following persons or agencies:

_____ _____

_____ _____

_____ _____

OR

☐ For all persons and agencies:

_____ _____

Signature of person giving consent or legal representative Date

Relationship to individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

Verbal Withdraw of Consent:

This consent was verbally withdrawn.

_____ _____

Signature of person receiving verbal withdraw of consent Date

☐ Individual provided copy ☐ Individual declined copy

INITIAL SERVICE PLAN

Date: _____Time IN: _____ OUT: _____Units: _____

Section I:

Client's Name: _____ Client's Number: _____

Diagnosis (DSM IV Number and Name): _____

Section II: Strengths and Weakness

Strengths: _____

Weakness: _____

Section III: Long Term View *(The long term view is both the focus and foundation of the Service planning process for each client. The long term view is an optimistic, yet realistic, narrative describing what the client would like to happen, with whom and where. This section reflects the expectations and desires of the client, where the client "sees" him or herself in the future. It is written in the first person by the client with help and support from the Case Manager).*

What I would like to happen: _____

What I want to accomplish regards with specific domains included in my Service Plan: _____

What I need to accomplish this: _____

Client's Name: _____ Client's Number: _____

Section IV: Needs *(The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)*

Domain's Legend: **1** -Behavioral **2**-Daily Living Skills **3**-Educational **4**-Substance Abuse **5**- Social Relationships **6**- Economical **7**- Legal **8**-Family **9**- Mental Health **10**-Physical Health **11**-Employment **12**-Living Environment **13**- Leisure Time **14**- Vocational **15**-Transportation

SERVICE AREA NEEDS *(Please include all needs identified, the date needs were identified and domain)*

Identified Need Goals Objective	**Tasks: Who will do what**		**Date Identified** Completion **Attained**	**Domain** (Name & number)	**Mark**
	Client will:	**Case Manager will:**			
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing

This Service Plan was developed in conjunction with the client, parent or legal guardian and was discussed and explained to client in terms he/she understands. This Service Plan is based on client's service needs and according with previous assessment completed in client's case.

Client's Name: _____ Client's Number: _____

Section IV: Needs *(The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)*

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					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing

This Service Plan was developed in conjunction with the client, parent or legal guardian and was discussed and explained to client in terms he/she understands. This Service Plan is based on client's service needs and according with previous assessment completed in client's case.

_____ _____ _____ _____

Client Signature Date Parent, Guardian or Surrogate Date

_____ _____

Case Manager Name, Signature and Credential Date

_____ _____

Supervisor Name, Signature and Credential Date

BEHAVIORAL SERVICE AGREEMENT *(Spanish Translation in the back)*

Client: _____

Medical Record: _____

VOLUNTARY ADMISSION: I VOLUNTARILY CONSENT TO ADMISSION TO THE AGENCY, AND TO TREATMENT THAT MAY BE ADVISED AND OR RECOMMENDED BY MY PHYSICIAN AND/OR PROGRAM TREATMENT TEAM.
I REQUEST A COPY OF THE PLAN OF TREATMENT: Y_____ N_____

CONSENT TO RECEIVE BEHAVIORAL SERVICES: I HEREBY AUTHORIZE THE AGENCY, TO RENDER APPROPRIATE BEHAVIORAL SERVICES AS PRESCRIBED BY MY PHYSICIAN AND/OR PROGRAM COORDINATOR, OR BY ANY OTHER PROGRAM WHO MAY BE SERVING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENT THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE PHYSICIAN. THE GOAL OF THE ASSESSMENT PROCESS IS TO DETERMINE THE BEST COURSE OF TREATMENT FOR YOU. THE TYPE AND EXTENT OF SERVICES THAT YOU WILL RECEIVE WILL BE DETERMINED FOLLOWING THE ASSESSMENT AND DISCUSSION WITH YOUR BEHAVIOR ANALYST . THE TREATMENT PLAN MAY INCLUDE: GROUP OR WORKSHOP, INDIVIDUAL BRIEF THERAPY AT HOME, THERAPIST ASSISTED ON-LINE (TAO), PSYCHIATRY SERVICES, CASE MANAGEMENT, REFERRALS FOR LONGER TERM THERAPY OR SPECIALIZED TREATMENT WITH A COMMUNITY PROVIDER, AND/OR REFERRALS TO OTHER HEALTH RESOURCES.

EMERGENCY MEDICAL SERVICES: I UNDERSTAND THAT DURING THE COURSE OF MY TREATMENT THE NEED FOR EMERGENCY TREATMENT AND/OR TREATMENT AND/OR TRANSFER TO A HOSPITAL MAY BECOME NECESSARY AND APPROPRIATE. I UNDERSTAND THAT THE AGENCY DOES NOT PROVIDE EMERGENCY MEDICAL CARE AND THEREFORE SHOULD THE NEED FOR SUCH TREATMENT AND/OR TRANSFER MAY BE DEEMED NECESSARY AND APPROPRIATE, THE AGENCY STAFF WILL CALL **911**. I CONSENT TO SUCH EMERGENCY TREATMENT AND/OR TRANSFER TO A HOSPITAL AND HEREBY INDEMNIFY THE AGENCY FROM SUCH EMERGENCY TREATMENT AND/OR TRANSFER. I AGREE TO ASSUME SOLE RESPONSIBILITY FOR ALL CHARGES INCURRED FOR SUCH TREATMENT.

ADVANCE DIRECTIVE AND LIVING WILLS: I HAVE RECEIVED WRITTEN INFORMATION REGARDING MY RIGHTS TO MAKE DECISIONS CONCERNING MEDICAL CARE, INCLUDING THE RIGHT TO ACCEPT OR REFUSE MEDICAL OR MENTAL TREATMENT AND THE RIGHT TO FORMULATE ADVANCE DIRECTIVES UNDER STATE LAW.
I HAVE AN ADVANCE DIRECTIVE: ___ YES ___ NO.
I HAVE A LIVING WILL: ___ YES ___NO. IF YES, LOCATION OF LIVING WILL:_____
I HAVE A PATIENT ADVOCATE/PROXY:___YES ___NO: MY PATIENT ADVOCATE/PROXY IS: Name: _____
_____ADDRESS:_____PHONE:_____
I WANT TO USE THE **DNR ORDER** ___ Y ___ N (If yes, complete the official Legal Form)

SECTION ONE
INSURANCE BENEFITS AND PAYMENT: I HEREBY AUTHORIZE MY INSURANCE CARRIER TO PAY INSURANCE BENEFITS TO THE AGENCY, AND AGREE TO THE RELEASE OF ALL MEDICAL INFORMATION TO MY INSURANCE CARRIER IF SHOULD BE REQUIRED BY ANY PROGRAM

☐ I HAVE BEEN ADMITTED THROUGH PROGRAM: _____
_____
_____
_____
_____

☐ I HAVE BEEN ADMITTED THROUGH **MEDICAID** AND MY RESPONSIBILITY IS $ 2.00 CO-PAY PER VISIT WITH A MAXIMUM OF ONE CO-PAYMENT PER DAY.

☐ I HAVE BEEN ADMITTED THROUGH _____HMO, _____COMMERCIAL INSURANCE,_____. The charges will be determined through third party contracts.

☐ I HAVE BEEN ADMITTED THROUGH **PRIVATE PAY** AND THE CHARGES ARE SPECIFIED IN THE SECTION TWO OF THE AGREEMENT.

I CERTIFY THAT THE FINANCIAL INFORMATION INDICATED ABOVE, RELATED TO THE PAYMENTS MADE BY INSURER OR THIRD PARTY PAYER, THE SCOPE AND INTENT OF COVERAGE, AND THE CHARGES FOR NON-COVERED SERVICE CHARGES, HAS BEEN EXPLAINED AND UNDERSTOOD.

SECTION TWO
HOME HEALTH SERVICES TO BE FURNISHED, FREQUENCY AND CHARGES:
BEHAVIORAL ANALYST_____ BEHAVIORAL ASSISTANT_____
TARGETED CASE MANAGER_____ MEDICAL SOCIAL WORKER _____
OTHER:_____
ALSO I AUTHORIZE THE AGENCY'S TO PERFORM NEEDED VISIT OF **SUPERVISIONS**.

STATEMENT OF PATIENT RIGHTS, RESPONSIBILITY AND ABUSE REGISTRY: I CERTIFY THAT I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITY WHICH HAS BEEN EXPLAINED TO ME VERBALLY BY A REPRESENTATIVE OF THE AGENCY. I RECEIVED ALL ADMISSION DOCUMENTS (GRIEVANCE PROCEDURE, EMERGENCY INFO, ETC) I UNDERSTAND THE POLICY AND HAVE RECEIVED A COPY WITH THE TOLL FREE ABUSE PHONE NUMBER (1-800-962-2873), AND HHA HOTLINE (1-888-419-3456).

HIPAA: NOTICE OF PRIVACY PRACTICES/CONFIDENTIALITY/PHI: I HAVE RECEIVED A COPY OF THE AGENCY'S NOTICE OF PRIVACY PRACTICES, I DISCUSS AND RECEIVE A COPY OF THE CLIENT INFORMATION HANDBOOK.

THE PURPOSE OF MEETING WITH A BEHAVIORAL COUNSELOR OR THERAPIST IS TO GET HELP WITH PROBLEMS IN YOUR LIFE THAT ARE BOTHERING YOU OR THAT ARE KEEPING YOU FROM BEING SUCCESSFUL IN IMPORTANT AREAS OF YOUR LIFE. YOU MAY BE HERE BECAUSE YOU WANTED TO TALK TO A COUNSELOR OR THERAPIST ABOUT THESE PROBLEMS. WHEN WE MEET, WE WILL DISCUSS THESE PROBLEMS. WE WILL ASK QUESTIONS, LISTEN TO YOU AND SUGGEST A PLAN FOR IMPROVING THESE PROBLEMS. IT IS IMPORTANT THAT YOU FEEL COMFORTABLE TALKING TO US ABOUT THE ISSUES THAT ARE BOTHERING YOU. AS A GENERAL RULE, WE WILL KEEP THE INFORMATION YOU SHARE WITH US IN OUR SESSIONS **CONFIDENTIAL**, UNLESS I HAVE YOUR WRITTEN CONSENT TO DISCLOSE CERTAIN INFORMATION. THERE ARE, HOWEVER, IMPORTANT EXCEPTIONS TO THIS RULE THAT ARE IMPORTANT FOR YOU TO UNDERSTAND BEFORE YOU SHARE PERSONAL INFORMATION WITH US IN A THERAPY SESSION. IN SOME SITUATIONS, WE ARE REQUIRED BY LAW OR BY THE GUIDELINES OF OUR PROFESSION TO DISCLOSE INFORMATION WHETHER OR NOT WE HAVE YOUR PERMISSION, SUCH AS: YOU TELL US YOU PLAN TO CAUSE SERIOUS HARM OR DEATH TO YOURSELF, YOU TELL US YOU PLAN TO CAUSE SERIOUS HARM OR DEATH TO SOMEONE ELSE WHO CAN BE IDENTIFIED, YOU ARE DOING THINGS THAT COULD CAUSE SERIOUS HARM TO YOU OR SOMEONE ELSE, YOU TELL ME YOU ARE BEING ABUSED-PHYSICALLY, SEXUALLY OR EMOTIONALLY-OR THAT YOU HAVE BEEN ABUSED IN THE PAST, YOU ARE INVOLVED IN A COURT CASE AND A LEGAL REQUEST IS MADE FOR INFORMATION ABOUT YOUR COUNSELING OR THERAPY.

MINOR CLIENTS: YOU MAY BE HERE BECAUSE YOUR PARENT, GUARDIAN, DOCTOR OR TEACHER HAD CONCERNS ABOUT YOU. EXCEPT FOR SITUATIONS SUCH AS THOSE MENTIONED ABOVE, WE WILL NOT TELL YOUR PARENT OR GUARDIAN SPECIFIC THINGS YOU SHARE WITH ME IN OUR PRIVATE THERAPY SESSIONS. THIS INCLUDES ACTIVITIES AND BEHAVIOR THAT YOUR PARENT/GUARDIAN WOULD NOT APPROVE OF — OR WOULD BE UPSET BY — BUT THAT DO NOT PUT YOU AT RISK OF SERIOUS AND IMMEDIATE HARM. HOWEVER, IF YOUR RISK-TAKING BEHAVIOR BECOMES MORE SERIOUS, THEN I WILL NEED TO USE MY PROFESSIONAL JUDGMENT TO DECIDE WHETHER YOU ARE IN SERIOUS AND IMMEDIATE DANGER OF BEING HARMED. IF WE FEEL THAT YOU ARE IN SUCH DANGER, WE WILL COMMUNICATE THIS INFORMATION TO YOUR PARENT OR GUARDIAN.

Adolescent therapy client: Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time. **___ N/A**

Minor's Signature _____ Date_____

Parent/Guardian: Check boxes and sign below indicating your agreement to respect your adolescent's privacy: **___ N/A**

___/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

___/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

___/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

PATIENT SERVICE AGREEMENT: I HAVE RECEIVED A COPY OF THE AGENCY'S CLIENT SERVICE AGREEMENT AND HAVE ALL QUESTIONS AND CONCERNS ANSWERED TO MY SATISFACTION. ALSO I AUTHORIZE TO _____, (RELATION TO PATIENT _____) **TO SIGN ALL DOCUMENTS**, BECAUSE I'M UNABLE TO DO SO. REASON UNABLE TO SIGN: _____

⇨

_____ _____ _____

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE RELATIONSHIP DATE

_____ _____

SIGNATURE OF AGENCY'S REPRESENTATIVE DATE

Initial Clinical Assessment (Adults)

NAME / MRN

Billing Information

Program Name:_____ RU:_____ Date:_____

Staff #: _____ **Hours:** _____ **Mins:** _____ Code Activity: ☐ **331** Assess ☐ **580** Lockout

Travel Time To/From included in above (if applicable) Hrs _____ Mins _____

Location of Services: (Please check one)

☐ 1 Office	☐ 5 School	☐ 11 Faith-based	☐ 15 LicCommCareFac (Adult)	☐ 19 Res Tx Ctr (Child)
☐ 2 Field	☐ 8 Corr Fac	☐ 12 Healthcare	☐ 16 Mobile Service	☐ 20 TeleHealth
☐ 3 Phone	☐ 9 Inpatient	☐ 13 Age-spec Comm Ctr	☐ 17 NonTradSvcLoc	☐ 21 Unknown
☐ 4 Home	☐ 10 Homeless/Shelter	☐ 14 Client's Job-site	☐ 18 Other	

Service Strategies: (Please check up to three, if applicable)

☐ 50 Peer/Fam Deliv Svcs	☐ 53 Supportive Education	☐ 56 Ptnrshp: Soc Svcs	☐ 59 Integrated Svcs: MH-Dvlp Disabled	
☐ 51 Psych Education	☐ 54 Prtnrshp: Law Enfcmt	☐ 57 Ptnrshp: Subs Abuse	☐ 60 Ethnic-Specific Service Strategy	
☐ 52 Family Support	☐ 55 Ptnrshp: Health Care	☐ 58 IntSvcs : MH / Aging	☐ 61 Age-Spec Svc Strategy	☐ 99 Unknown

Referred By: _____

Identifying Information:

Legal Name:_____ Age:____ DOB:_____

Preferred Name: _____

Gender: ☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Address: _____

Phone #: _____

Emergency Contact: _____ _____
Name Phone

Language:

Primary Language: _____ Other Languages spoken in home: _____

☐ Interpreter Name of Interpreter _____

Language service provided in other than English: ☐ Spanish ☐ Other _____

Client Information:

Entitlements: ☐ M/C ☐ Medicare ☐ BHC ☐ Other Health Care Info _____
☐ No Health Insurance Coverage
☐ SSI ☐ SSDI Payee: _____
Monthly Income: _____ Refer to a Financial Counselor? ☐ Yes ☐ No

Living Situation: ☐ Independent Living ☐ Immediate Family ☐ Extended Family ☐ Shared Housing
☐ Board & Care ☐ Residential Care Facility ☐ Homeless ☐ Other

Support System Contacts: _____

Other Agencies Involved: ☐ CC Provider Network ☐ CFS/APS ☐ Voc Services ☐ Regional Center
☐ MHCC ☐ AOD ☐ Anka BHI ☐ Homeless Services
☐ Other _____

NAME / MRN

Presenting Problem: (What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms and functional impairment.)

Relevant Family/Social History: (Summarize relevant data regarding significant interpersonal relationships, including parents and marital status, children, siblings, living situations, education, work, history, military history, current support system, family history of mental illness or substance abuse and major traumatic events/losses, adverse childhood experiences.)

NAME / MRN

Treatment History: (Check all appropriate and comment below.)

☐ Yes ☐ No	Previous outpatient mental health services? Where/When? ☐ Transfer
☐ Obtain Release of Information for records from above (as needed)	
☐ Yes ☐ No	Previous crisis contact? Number of crisis unit visits without hospitalization in past 6 months ☐0 ☐1 ☐2 or more Most recent date:
☐ Yes ☐ No	Previous psychiatric hospitalization(s)? # Most recent date:
☐ Yes ☐ No	Previous residential treatment? Name of program: Length of stay:
☐ Yes ☐ No	Previous day treatment/partial hospitalization program? Name of program: Length of stay:
☐ Yes ☐ No	Use of non-traditional or alternative healing practices (If yes, list): _____

Risk Assessment:

Danger to self (Intent, Plan Means): _____

Past: _____

Danger to others (Intent, Plan Means): _____

Past: _____

Grave Disability (Unable to make use of available Resources): _____

☐ 5150 Initiated ☐ CPS Referral/Involvement ☐ APS Referral ☐ Tarasoff

Additional Risk Factors: (Check all that apply) Document details

☐ Family History of Suicide
☐ History of Domestic Violence
☐ Sexual Abuse
☐ Adverse Childhood
☐ Trauma or Loss in Family
☐ Physical Abuse/Emotional Abuse
☐ Inappropriate Sexualized Behavior
☐ Impulsivity/Threatening Behavior
☐ Animal Cruelty
☐ Fire Setting
☐ Emotional/Physical Neglect
☐ Substance Abuse
☐ Self-Injurious Behavior
☐ Access to Firearms (family, friends)
☐ Behavior Influences by Delusions or Hallucinations
☐ Severe Hopelessness
☐ Other _____

Comments:

NAME / MRN

Medical History: ☐ Not available
Current Primary Medical Care Provider: _____ ☐ None ☐ Unknown

Last Physical Exam: ☐ Within Past 12 months ☐ NOT Within Past 12 months ☐ Unknown

Last Dental Exam: ☐ Within Past 12 months ☐ NOT Within Past 12 months ☐ Unknown

Are there any health concerns (medical illness, medical symptoms)? ☐ No ☐ Yes (If so, please describe)

Has client had ANY allergic/serious reactions to medication(s)? ☐ No ☐ Yes (If yes, which medication(s)?)

Does client have any NON medication allergies (Food, pollen, bee strings, etc.)? ☐ No ☐ Yes (If so, please describe)

List name of any medication(s) client is taking at this time. (List all current medications including Psychiatric, OTC, herbal and homeopathic. Include Start date/Dose/Frequency.)

Compliance Issues? ☐ No ☐ Yes (If so, please describe)

☐ Referral to Health Care Provider for Further Evaluation/Assessment

NAME / MRN

Criminal Justice History:

☐ Probation ☐ Parole ☐ None

Probation/Parole Officer Contact: _____ ☐ Obtain Release (ROI)

Offense History (include jail/prison facility): _____

_____

Substance Use:

During the past 6 months:

1. Have you ever used alcohol or drugs (such as wine, beer, hard liquor, pot, coke, heroin, or other opiods, uppers, downers, hallucinogens or inhalants)? ☐ Yes ☐ No

Check all substances that apply in the last 6 months:

	FREQUENCY		FREQUENCY
☐ ALCOHOL	_____	☐ DESIGNER DRUGS (GHB, PCP, Ecstasy)	_____
☐ AMPHETAMINE	_____	☐ INHALANTS (Paint, Gas, Aerosols)	_____
☐ COCAINE/CRACK	_____	☐ MARIJUANA	_____
☐ OPIATES (Heroin, Opium, Methadone)	_____	☐ TOBACCO	_____
☐ HALLUCINOGENS (LSD, Mushrooms, Peyote)	_____	☐ CAFFEINE (Energy Drinks, Sodas, Coffee, etc.)	_____
☐ PAIN KILLERS (Oxy, Norco, Vicodin)	_____	☐ OVER THE COUNTER _____	_____
☐ Other _____			

Has alcohol or drugs ever been a problem in your life? ☐ Yes ☐ No (If no, skip questions 2 – 19)

Frequency of use _____

2. Have you felt that you use too much alcohol or drugs? ☐ Yes ☐ No

3. Have you tried to cut down or quit drinking or using alcohol or drugs? ☐ Yes ☐ No

4. Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)? ☐ Yes ☐ No

5. Have you had any of the following due to substance use?

☐ Had blackouts or other periods or memory loss?	☐ Felt sick, shaky, or depressed?
☐ Injured your head after drinking or using drugs?	☐ Felt "coke bugs" or a crawling feeling under the skin?
☐ Had convulsions or delirium tremens ("DTs")?	☐ Been injured after drinking or using drugs?
☐ Had Hepatitis or other liver problems?	☐ Used needles to shoot drugs?

6. Has drinking or drug use caused problems between you and your family or friends? ☐ Yes ☐ No

7. Has your drinking or drug use caused problems at school or at work? ☐ Yes ☐ No

8. Have you been arrested or had other legal problems due to substance use (such as bouncing bad checks, driving while intoxicated, theft, or drug possession? ☐ Yes ☐ No

Describe: _____

_____

NAME / MRN

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? ☐ Yes ☐ No
10. Are you needing to drink more and more to get the effect you want? ☐ Yes ☐ No
11. Do you spend a lot of time thinking or trying to get the effect you want? ☐ Yes ☐ No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ☐ Yes ☐ No
13. Do you feel bad or guilty about your drinking or drug use? ☐ Yes ☐ No
14. Have any of your family members ever had a drinking or drug problem? ☐ Yes ☐ No
15. Do you feel that you have a drinking or drug problem now? ☐ Yes ☐ No
16. What contributing factors/triggers do you have to drug/alcohol abuse?
17. Clean & Sober ___ Month(s) ___Year(s) What has been most helpful to you in maintaining sobriety?
18. Are you currently or ever been in recovery?
19. What recovery models have you used?

Comments:

NAME / MRN

Mental Status:

General (Appearance, attitude, behavior, speech): _____

Orientation: _____

Mood/Affect: _____

Thought Process: _____

Memory/Thought Content: _____

Insight/Judgment/Impulsivity: _____

Additional Observation: _____

Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a "P"

Axis I _____ P _____

Axis I _____ S _____

Axis I _____ _____

Axis II _____ P/S _____

Axis III _____ By History, check if None ☐

Axis IV CONTRIBUTING STRESSORS – Problems related to:

☐ A – Primary Support ☐ B – Social Environment ☐ C - Education ☐ D – Occupation
☐ E – Housing ☐ F - Economic ☐ G – Access to Health Care ☐ H – Legal System
☐ I – Other

Axis V CURRENT GAF: _____ HIGHEST GAF PAST YEAR: _____

DSM Diagnosis by: _____
Name of Licensed Clinician

FUNCTIONAL IMPAIRMENT: (IF MODERATE OR ABOVE, MAY WARRANT TARGETED CASE MANAGEMENT)

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Social Relations	☐	☐	☐	☐
Employment/School Performance	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Recreational/Leisure Activities	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐

NAME / MRN

Initial Treatment Plan (e.g. MHS, Medication Support, Day Treatment, etc.):

Clinical Summary / Additional Comments:

Preliminary Discharge Plan:

Staff Signature/License | Printed Name | Date

Co-Signature of Licensed Clinician | Date

Data Entry Clerk Initials

NAME / MRN

Presenting Problem**:** ***(Continued from page 2)***

NAME / MRN

ASSESSMENT OF STRENGTHS

Check all that apply:

- ☐ Optimism / Hope
- ☐ Sense of Meaning
- ☐ Faith / Spirituality
- ☐ Empathy
- ☐ Compassion
- ☐ Resourcefulness
- ☐ Academic Accomplishments
- ☐ Daily Living Skills
- ☐ Flexibility
- ☐ Sense of Humor
- ☐ Support Relationship
- ☐ Friendships
- ☐ Open to Change
- ☐ Exercises Regularly
- ☐ Nutritional Awareness
- ☐ Understands Mental Illness / Needs
- ☐ Participates in 12 Step Program
- ☐ Participates in Self-Help Groups
- ☐ Able to voice Mental Health life needs
- ☐ Wellness Recovery Action Plan
- ☐ Able to Recognize Mental Health / Life Choices
- ☐ Hobbies / Special Interests
- ☐ Goal-Directed / Motivated
- ☐ Stable Family Life
- ☐ Communication
- ☐ Sense of Empowerment
- ☐ Work History
- ☐ Employment Skills
- ☐ Living Environment
- ☐ Positive Self Identity
- ☐ Cultural Identity / Integration
- ☐ Resilience
- ☐ Planning
- ☐ Other _____

Completed by: ☐ Therapist ☐ Consumer

Initial Clinical Assessment for Children

NAME / MRN

Program Name: _____ RU: _____ Date_____

Staff #: _____ **Hours:** _____ **Mins:** _____ Code Activity: ☐ **313** Eval ☐ **331** Assess ☐ **580** Lockout

Travel Time To/From included in above (if applicable) Hrs _____ Mins _____

Location of Services: (Please check one)

☐ **1**Office	☐ **4**Home	☐ **9**Inpatient	☐ **12**Healthcare	☐ **15**LicCommCareFac (Adult)	☐ **18**Other
☐ **2**Field	☐ **5**School	☐ **10**Homless/Shlter	☐ **13**AgeSpcCommCtr	☐ **16**Mobile Service	☐ **19**Res Tx Ctr (Child)
☐ **3**Phone	☐ **8**CorFac	☐ **11**Faith-based	☐ **14**Client Job-site	☐ **17**NonTradSvcLoc ☐ **20**Telehealth	☐ **21**Unknown

Service Strategies: (Please check up to three, if applicable)

☐ **50** Peer/Fam Deliv Svcs	☐ **53** Supportive Education	☐ **56** Ptnrshp: Soc Svcs	☐ **59** Integrated Svcs: MH-Dvlp Disabled
☐ **51** Psych Education	☐ **54** Prtnrshp: Law Enfcmt	☐ **57** Ptnrshp: Subs Abuse	☐ **60** Ethnic-Specific Service Strategy
☐ **52** Family Support	☐ **55** Ptnrshp: Health Care	☐ **58** IntSvcs: MH/Aging	☐ **61** AgeSpcSvcStrgy ☐ **99** Unknown

Identifying Information:

Name: _____ ☐ Male ☐ Female Age/ DOB: _____

Address: _____

Phone: _____

Referred By:

Language:

Child's Primary Language: _____ Parent's Primary Language: _____ Other Languages Spoken in Home: _____

☐ Interpreter Name of Interpreter_____

Language service provided in other than English: ☐ Spanish ☐ Other:_____

Presenting Problem: (What is the primary reason for current referral. Include description and timelines of current emotional and behavioral symptoms & current functional impairment. Describe relevant stressors.)

MRN/Last Name_____

Client Information:

Lives With: ☐ Immed. Family ☐ Extend. Family ☐ Unrel. Foster Family ☐ Jail/Juvenile Hall
☐ Acute Hospital ☐ Group Homes ☐ Emergency Foster Care ☐ Residential ☐ Other _____

Residential Contact (Name & Phone): _____

Others in Home/Ages/Relationship to Child: _____

_____

_____

Composition of Family of Origin: (If different from above) _____

_____

_____

Current Legal Status:
☐ Independent Adult or Child in custody of Biological Parent(s), Adoptive Parent(s), or Legal Guardian(s)
☐ Emancipated Minor ☐ Juv Dependent of Court (DCFS 300) ☐ Juvenile Ward (Probation 602)
☐ Other _____

Agencies/Other MH Providers Involved: (Check all that apply. Include contact names & phone numbers as appropriate.)

☐ CC Mental Health/AB3632 _____ ☐ CFS _____
☐ Aid to Adoptive Parents _____ ☐ SSI/SSDI _____
☐ Outside Therapists _____ ☐ Special Ed _____
☐ Regional Center _____ ☐ Probation _____ ☐ Other _____

_____

Developmental History:

☐ Birth and Developmental History is not available. Birth was: ☐ On-Time ☐ Early (<36 weeks) ☐ Late

While pregnant, did mother have any injuries, illnesses, physical traumas or use alcohol or drugs?	☐ No	☐ Yes
Were there any complications at time of birth?	☐ No	☐ Yes
Did the child experience any traumas during first 5 years	☐ No	☐ Yes
Did the child have any sleep, eating or social problems the first 5 years?	☐ No	☐ Yes

If "Yes" to any of the above, please describe:_____

_____

_____

Developmental Milestones: ☐ Early ☐ On Time ☐ Delayed (If Delayed, please describe):_____

_____

Family/Social History: (Summarize relevant data regarding significant interpersonal relationships, including parents and siblings; living situations; family history of mental illness or substance abuse; and major traumatic events/losses):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NAME/MRN _____

Medical History: ☐ Not Available

Current Primary Medical Care Provider: _____ ☐ None ☐ Unknown

Last Physical Exam: ☐ Within Past 12 months ☐ NOT Within Past 12 months ☐Unknown

Last Dental Exam: ☐ Within Past 12 months ☐ NOT Within Past 12 months ☐Unknown

Are there any health concerns (medical illness, medical symptoms) regarding this child? ☐ No ☐ Yes (If so, please describe):

_____

_____

Has child had ANY allergic/serious reactions to medication(s)? ☐ No ☐ Yes (Which medication(s)?_____

_____

_____

*Please describe reaction(s):*_____

Does child have any NON medication allergies (Food, pollen, bee stings, etc)? ☐ No ☐ Yes (If so, please describe):

_____

_____

List name of any medication(s) child is taking at this time: (List all current medications including OTC, herbal and homeopathic):

_____

_____

Compliance Issues? ☐ No ☐ Yes (If so, please describe):_____

_____

_____

Has child had any of the following problems/experiences? (Check all that apply):

☐ Asthma	☐ Hearing or Vision Problem	☐ Sexually Transmitted Disease (STD)
☐ Broken Bone(s)	☐ Heart Problem	☐ Sleep Problem
☐ Concentration Problem	☐ High or Low Blood Pressure	☐ Speech or Language Problem
☐ Convulsion or Seizure	☐ Immune System Problem	☐ Surgery of any kind
☐ Diabetes	☐ Liver Problems or Hepatitis	☐ Thyroid Problem
☐ Eating or Appetite Problem	☐ Memory or Thought Problem	☐ Tuberculosis (TB)
☐ Energy or Motivation Problem	☐ Motor or Movement Problem	☐ Urinary Tract or Kidney Problem
☐ Exposure to Toxic Lead Levels	☐ Pregnancy	☐ Weight Gain or Loss
☐ Head Injury, Significant	☐ Serious Rash or Other Skin Problem	☐ Other Medical Problem:_____

Please describe any checked items: _____

_____

_____

_____

Substance Use History: (Check all appropriate)

☐Unknown ☐ No Current or Past Substance Abuse ☐ Currently Clean & Sober for: ☐ >3 Months ☐ >1 Year

Alcohol	☐ Past	☐ Present	**Nicotine**	☐ Past	☐ Present	**Caffeine**	☐ Past	☐ Present
Cocaine	☐ Past	☐ Present	**Marijuana**	☐ Past	☐ Present	**Amphetamines**	☐ Past	☐ Present
Opiates	☐ Past	☐ Present	**Ecstasy**	☐ Past	☐ Present	**Hallucinogens**	☐ Past	☐ Present
Sedatives	☐ Past	☐ Present	**Inhalants**	☐ Past	☐ Present			
Other:	☐ Past	☐ Present	Specify: _____					

_____

_____

_____

MRN/Last Name_____

Treatment History: (Check all appropriate and comment below)

☐ Psych Hospitalization ☐ Psych Medication ☐ Residential Treatment ☐ Day Treatment
☐ Substance Abuse Program ☐ Psychotherapy ☐ Testing- *Psychological/Neurological/Educational*

Comments on above History:_____

_____

_____

Risk History: (Check all that apply)

☐ Physical Abuse
☐ Suicide Attempt
☐ Assaultive Behavior
☐ Inappropriate Sexualized Behavior
☐ Witness to Domestic Violence
☐ Extended Truancy or Runaway
☐ Sexual Abuse
☐ Suicide Ideation
☐ Self-injurious Behavior
☐ Trauma or Loss in Family
☐ Witness to Community Violence
☐ Behavior Influenced by Delusions or Hallucinations
☐ Threat of, or Recent Removal from, Home Placement
☐ Other _____

_____

_____

_____

_____

How are arguments handled in the family? _____

Is there any pushing/shoving/hitting/name calling/threats? _____

_____

Child's Education History

Current School:_____ Grade: _____ Contact:_____

School Performance – In and Out of Classroom

Usual Grades: ☐ Exceptional ☐ Above Average ☐ Average ☐ Below Average ☐ Failing

Academic Stengths:_____

Academic Challenges:_____

Names of previous schools:_____

_____

Has child been held back a grade? ☐ No ☐ Yes If Yes, Year(s)_____

Has child ever been expelled from school? ☐ No ☐ Yes If Yes, Year(s)_____

If child was ever held back or expelled, please explain:_____

_____

_____

Has child ever been considered for Special Education? ☐ No ☐ Yes

Has child ever qualified for Special Education? ☐ No ☐ Yes If Yes, Grade _____

Is child receiving Special Education services now? ☐ No ☐ Yes If Yes, please describe _____

_____

School Attendance: Current (or Most Recent) School Year:

Absent due to Illness:	☐ Never	☐ Seldom	☐ Frequently
Absent due to Truancy:	☐ Never	☐ Seldom	☐ Frequently
Absent due to Suspension:	☐ Never	☐ Seldom	☐ Frequently

Has child been referred to SARB? ☐ No ☐ Yes

NAME/MRN _____

Behavior and Social Relationships:

Has child had problems with peers? ☐ No ☐ Yes

Has child had problems with teachers/authorities? ☐ No ☐ Yes

If yes, please describe: _____

_____

_____

Extracurricular Interests/Activities: (e.g. Work, clubs, church groups, arts, music, sports, exercise) _____

_____

Child & Family Strengths

_____

_____

Mental Status: (Check and/or describe if abnormal or impaired)

APPEARANCE/GROOMING	☐ Unremarkable	Remarkable for: _____		
BEHAVIOR/RELATEDNESS	☐ Unremarkable	☐ Motor Agitated	☐ Inattentive	☐ Avoidant
		☐ Impulsive	☐ Motor Retarded	☐ Hostile
		☐ Suspicious/Guarded	☐ Other _____	
SPEECH	☐ Unremarkable	Remarkable for: _____		
MOOD/AFFECT	☐ Unremarkable	☐ Depressed	☐ Elated/Expansive	☐ Anxious
		☐ Labile/Irritable	☐ Other _____	
THOUGHT PROCESSES	☐ Unremarkable	☐ Concrete	☐ Distorted	☐ Disorganized
		☐ Odd/Idiosyncratic	☐ Blocking	☐ Paucity of Content
		☐ Circumstantial	☐ Tangential	☐ Obsessive
		☐ Flight of Ideas	☐ Racing Thoughts	☐ Loosening of Assoc
			☐ Other: _____	
THOUGHT CONTENT	☐ Unremarkable	☐ Suicidal Ideation	☐ Homicidal	☐ Paranoid Ideation
			☐ Other: _____	
PERCEPTUAL CONTENT	☐ Unremarkable	☐ Hallucinations	☐ Delusions	☐ Ideas of Reference
		☐ Flashbacks	☐ Depersonalization	☐ Derealization
		☐ Dissociation	☐ Other: _____	
FUND OF KNOWLEDGE	☐ Unremarkable	Remarkable for: _____		
ORIENTATION	☐ Unremarkable	Remarkable for: _____		
MEMORY	☐ Intact	Impaired: _____		
INTELLECT	☐ Unremarkable	Remarkable for: _____		
INSIGHT/JUDGMENT	☐ Unremarkable	Remarkable for: _____		

Additional Observations: _____

RISK ASSESSMENT:	☐ None Identified	☐ Danger to Self	☐ Danger to Others	☐ Inability to Care for Self
REPORT FILED:	☐ CPS	☐ APS	☐ DUTY TO WARN	☐ Weapons Confiscated

MRN/Last Name_____

Diagnostic Impression: DSM Code and Narrative - Designate primary diagnosis with a "P"

Axis I		
Axis II		

Axis III _____ **Check if None** ☐

Axis IV **CONTRIBUTING STRESSORS – Problems related to:**

☐ **A** – Primary Support ☐ **B** – Social Environment ☐ **C** – Education (D-Occupation) ☐ **E** – Housing

☐ **F** – Economic ☐ **G** – Access to Health Care ☐ **H** – Legal System ☐ **I** – Other

Axis V **CURRENT GAF:**_____ **HIGHEST GAF PAST YEAR:**_____

DSM Diagnosis by: _____
(Name of Licensed Clinician)

FUNCTIONAL IMPAIRMENT:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	**Peer Relations**	☐	☐	☐	☐
School Performance	☐	☐	☐	☐	**Physical Health**	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	**Substance Abuse**	☐	☐	☐	☐

TARGETED SYMPTOMS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	**Perceptual Disturbance**	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	**Oppositional/Conduct**	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	**Destructive/Assaultive**	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	**Mania/Agitation/Lability**	☐	☐	☐	☐
Anxiety/Phobia/Panic Attack	☐	☐	☐	☐	**Somatic Disturbance**	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	**Other**_____	☐	☐	☐	☐

Initial Treatment Plan:

_____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____ _____
Staff Signature/License Date

_____ _____
Co-Signature of Licensed Clinician Date

_____
Data Entry Clerk Initials

Adult Annual Clinical Update

NAME / MRN

Billing Information

Program Name:_____ RU:_____ Date: _____

Staff #: _____ **Hours**: _____ **Mins**: _____ Code Activity: ☐ **331** Assessment ☐ **580** Lockout

Travel Time To/From included in above (if applicable) Hrs _____ Mins _____

Location of Services: (Please check one)

☐ 1 Office	☐ 5 School	☐ 11 Faith-based	☐ 15 LicCommCareFac (Adult)	☐ 19 Res Tx Ctr (Child)
☐ 2 Field	☐ 8 Cor Fac	☐ 12 Healthcare	☐ 16 Mobile Service	☐ 20 TeleHealth
☐ 3 Phone	☐ 9 Inpatient	☐ 13 Age-spec Comm Ctr	☐ 17 NonTradSvcLoc	☐ 21 Unknown
☐ 4 Home	☐ 10 Homeless/Shelter	☐ 14 Client's Job-site	☐ 18 Other	

Service Strategies: (Please check up to three, if applicable)

☐ 50 Peer/Fam Deliv Svcs	☐ 53 Supportive Education	☐ 56 Ptnrshp: Soc Svcs	☐ 59 Integrated Svcs: MH-Dvlp Disabled	
☐ 51 Psych Education	☐ 54 Prtnrshp: Law Enfcmt	☐ 57 Ptnrshp: Subs Abuse	☐ 60 Ethnic-Specific Service Strategy	
☐ 52 Family Support	☐ 55 Ptnrshp: Health Care	☐ 58 IntSvcs : MH / Aging	☐ 61 Age-Spec Svc Strategy	☐ 99 Unknown

☐ **Interpreter** Name of Interpreter: _____

Language service provided in other than English: ☐ Spanish ☐ Other _____

Identifying Information:

Name:_____ Age:____ DOB:_____

Address:_____ Phone_____ Marital Status: S ☐ M ☐ D ☐ P ☐

Emergency Contact/Name & Phone: _____

MH Provider: _____

Current Mental Health Functioning: (Include current symptoms, improvements in functioning, on-going functional impairments, hospitalizations and other pertinent changes in past year.)

Strengths:

Name: _____

MRN: _____

Family/Social/Economic Update: (Include living situation, income, socialization, work or educational activity, judicial involvement, support system and any changes in life circumstances.)

Functional Impairment: (IF MODERATE OR ABOVE, MAY WARRANT TARGETED CASE MANAGEMENT

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Social Relations	☐	☐	☐	☐
Employment / School Performance	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Recreational / Leisure Activities	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐

Additional Comments:

Medical History:

Primary Care Provider: _____ Last Physical Exam:_____ Last Dental Exam: _____

Psychiatrist_____ Location _____

List all Medical Conditions: _____

_____

_____

_____

_____

Allergies/Drug Reactions: _____

Med Compliant? ☐ Yes ☐ No ☐ Unknown

List name of medication(s) client is taking at this time.
(List all current meds including OTC, herbal, and homeopathic. Include start date/dose/frequency.)

_____

_____

_____

Substance Use:

☐ No Past Substance Abuse ☐ Actively Using Substances ☐ Currently Clean & Sober for: _____

Please list all substance being used or list current treatment interventions.

_____

_____

_____

_____

Name: _____

MRN: _____

Risk Assessment:

Danger to Self (Intent, Plan, Means): _____

Past: _____

Danger to others: (Intent, Plan, Means): _____

Past: _____

Grave Disability (unable to make use of available resources): _____

☐ 5150 Initiated ☐ CPS Referral ☐ APS Referral ☐ Tarasoff ☐ Arrests/Incarcerations in last 12 months

Additional Risk Factors: (Check all that apply.) Document details.

☐ Physical Abuse/Emotional Abuse	☐ Sexual Abuse	☐ Self-injurious Behavior
☐ Family History of Suicide	☐ Animal Cruelty	☐ Trauma or Loss in Family
☐ Assaultive Behavior	☐ Fire Setting	☐ Access to Firearms (family, friends)
☐ Inappropriate Sexualized Behavior	☐ Emotional/Physical Neglect	☐ Behavior Influences by Delusions or Hallucinations
☐ History of Domestic Violence	☐ Adverse Childhood Experience	☐ Severe Hopelessness
☐ Impulsivity/Threatening Behavior	☐ Substance Abuse	☐ Other _____

Comments:

Mental Status:

General (Appearance, attitude, behavior, speech) : _____

Orientation : _____

Mood/Affect : _____

Thought Process : _____

Memory/Thought Content : _____

Insight/ Judgment/ Impulsivity : _____

Additional Observation : _____

Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a "P"

Axis I _____ P _____

Axis I _____ S _____

Axis I _____ _____

Axis II _____ P/S _____

Axis III _____ By History, check if None ☐

Axis IV CONTRIBUTING STRESSORS – Problems related to:

☐ A – Primary Support ☐ B - Social Environment ☐ C - Education ☐ D - Occupation
☐ E – Housing ☐ F - Economic ☐ G – Access to Health Care ☐ H - Legal
☐ I - Other

Axis V Current GAF: _____ HIGHEST GAF PAST YEAR: _____

DSM Diagnosis by: _____
Name of Licensed Clinician

Name: _____

MRN: _____

Clinical Summary / TCM (Linkage/Referrals) / Justification for Continued Care Services

Discharge Plan Update: (Clinical Presentation)

Staff Signature/License _____ Printed Name _____ Date _____

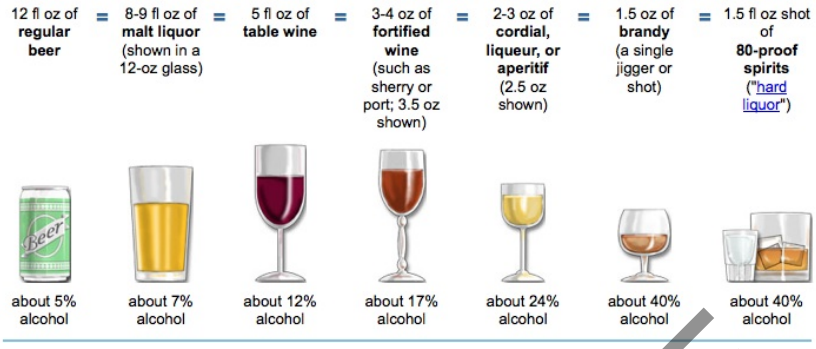
Co-Signature of Licensed Clinician _____ Date _____

Data Entry Clerk Initials _____

YOUR NAME:_____ **DATE:** _____ **DOB:** _____

Alcohol Use Disorders Identification Test (AUDIT)

Please respond to these questions about your use of alcoholic beverages. Standard drink sizes are shown in the pictures below. Place an X in one box that best describes your answer to each question.



	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No	Yes, but not in the last year	Yes, during the last year		
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year	Yes, during the last year		

Total for #s 1-3

Total

Annual Clinical Update for Children

NAME / MRN

Program Name: _____ RU: _____ Date _____

Staff #: _____ Hours: _____ Mins: _____ Code Activity: ☐ **313** Eval ☐ **331** Assess ☐ **580** Lockout

Travel Time To/From included in above (if applicable) Hrs _____ *Mins* _____

Location of Services: (Please check one)

☐**1** Office	☐**4** Home	☐**9** Inpatient	☐**12** Healthcare	☐**15** LicCommCareFac (Adult)	☐**18** Other	
☐**2** Field	☐**5** School	☐**10**Homless/Shlter	☐**13** AgeSpcCommCtr	☐**16** Mobile Service	☐**19** Res Tx Ctr (Child)	
☐**3** Phone	☐**8**CorFac	☐**11** Faith-based	☐**14** Client Job-site	☐**17** NonTradSvcLoc	☐**20**Telehealth	☐**21** Unknwn

Service Strategies: (Please check up to three, if applicable)

☐ **50** Peer/Fam Deliv Svcs	☐ **53** Supportive Education	☐ **56** Ptnrshp: Soc Svcs	☐ **59** Integrated Svcs: MH-Dvlp Disabled
☐ **51** Psych Education	☐ **54** Prtnrshp: Law Enfcmt	☐ **57** Ptnrshp: Subs Abuse	☐ **60** Ethnic-Specific Service Strategy
☐ **52** Family Support	☐ **55** Ptnrshp: Health Care	☐ **58** IntSvcs: MH/Aging	☐ **61**AgeSpcSvcStrtgy ☐ **99** Unknown

Synopsis of Interim History: (Describe consumer/family accomplishments, improvements and strengths. Describe continuing needs and challenges in the areas of clinical symptoms, functional status and life circumstances.)

Educational and Medical Update:

Highest grade completed: _____ Current School: _____

Last Physical Exam: ☐ Within past 12 months ☐NOT Within past 12 months ☐ Unknown

Last Dental Exam: ☐ Within past 12 months ☐NOT Within past 12 months ☐ Unknown

Allergy Assessment: (Allergen:Reaction) ☐ NKA _____

Current Medications: (Include psychotropic, non-psychiatric, OTC, herbal and homeopathic remedies)

MRN/Last Name _____

Update of Assessment Data:

Identification Data:	☐No Change Indicated	☐ Updated	(See current Episode Opening Form)
Agencies Involved:	☐No Change Indicated	☐ Updated	[Change detailed below]
Primary Caregiver	☐No Change Indicated	☐ Updated	
Legal Status:	☐No Change Indicated	☐ Updated	
Mental Health	☐No Change Indicated	☐ Updated	
Medical History:	☐No Change Indicated	☐ Updated	
Educational History:	☐No Change Indicated	☐ Updated	

Diagnostic Impression: DSM Code and Narrative (Primary diagnosis must be congruent with diagnosis on face sheet. Please make changes as needed. Designate Primary diagnosis with a "P".)

Axis I

Axis II

Axis III _____ Check if None ☐

Axis IV **CONTRIBUTING STRESSORS – Problems related to:**

☐ **A** – Primary Support ☐ **B** – Social Environment ☐ **C** – Education (D-Occupation) ☐ **E** – Housing

☐ **F** – Economic ☐ **G** – Access to Health Care ☐ **H** – Legal System ☐ **I** – Other

Axis V **CURRENT GAF:**_____ **HIGHEST GAF PAST YEAR:**_____

DSM Diagnosis by: _____

(Name of Licensed Clinician)

FUNCTIONAL IMPAIRMENT:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	**Peer Relations**	☐	☐	☐	☐
School Performance	☐	☐	☐	☐	**Physical Health**	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	**Substance Abuse**	☐	☐	☐	☐

TARGETED SYMPTOMS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	**Perceptual Disturbance**	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	**Oppositional/Conduct**	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	**Destructive/Assaultive**	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	**Mania/Agitation/Lability**	☐	☐	☐	☐
Anxiety/Phobia/Panic Attack	☐	☐	☐	☐	**Somatic Disturbance**	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	**Other**_____	☐	☐	☐	☐

ADDITIONAL COMMENTS:

Staff Signature/License Date

Co-Signature of Licensed Clinician Date

Print Name

Data Entry Clerk Initials (Verify Primary diagnosis & enter into PSP if changed)

BEHAVIOR SERVICES
PROGRESS NOTE REPORT

Date: _____ Time IN: _____
OUT: _____
Therapy duration: _____ (hours/minutes)

Client Name: _____ Med. Record: _____

BA/RBT Name: _____ Title: _____

Place of Services: ☐ Home ☐ Community ☐ Office ☐ Other: _____
Communication with other Entity ☐Yes ☐No If yes, explain: _____
Doctor Appointment from previous session: ☐ Yes ☐ No
Medication change: ☐ Yes ☐ No If Yes, explain: _____
Environment change: ☐ Yes ☐ No If Yes, explain: _____

Response to interventions:
The client had a ☐Good ☐ Fair ☐Poor participation during session: _____

Document all PROBLEM BEHAVIORS and the number of times each occurred during this session: (specify maladaptive behaviors) (Interrupt Behavior (which Behavior))

_____
_____
_____
_____
_____
_____

Document all REPLACEMENT AND ACQUISITION skills, interventions used during this session:

_____
_____
_____
_____
_____
_____

Other: ☐ Media/Environmental changes ☐ communication/report with/from other entity such as school, OT, ST
☐ Reinforcers unavailable ☐ visitors ☐ changes in routine ☐ raining/hot/cold ☐ minor incident
☐ Any difficult implementing BASP

_____
_____
_____
_____
_____

Replacement program specify _____ ☐ N/A
_____

Implemented today: _____ ☐ N/A

_____ _____ _____
Parent/Caregiver Signature BCBA/BCaBA/LCSW/LMFT Signature/Title BA/RBT Signature/Title

BEHAVIORAL SERVICES STAFF AGREEMENT ADDENDUM

Staff Name: _____ Title: _____

Behavioral care Individuals served by a our home health agency must have one or more chronic conditions such as a mental health or substance use condition, asthma, diabetes, heart disease, or be overweight. Regardless of which conditions the state may select for focus, and must address mental health and substance use disorders prevention and treatment services and consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) on how it proposes to provide these services.

As part of your application process, our Agency invest in your training, orientation and preparation to be in the best way possible, ready to serve our clients, and be part of the community that we serve. Also we invest in other structures, application process, consulting, rules, to maintain our level of services in the greatest standards.

You must agree, to be part of our staff:

- that at least for a year, you will serve the assigned patients to you, as part of your independent employment
- You will not attempt, to transfer our clients to another home health agency
- You will not abandon the clients that you serve
- You will not accept clients from another home health agency, due to clients limitations that your license required
- Other: _____

Staff Signature: _____

Date: _____

CHILDREN/ADOLESCENT MEDICAL NECESSITY CRITERIA

Children or adolescents will be provided Mental Health Services where such services are deemed medically necessary. Medical necessity will be defined as (1) having a 5-Axis diagnosis with a primary Axis I diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Diagnosis (2) evidence of impaired functioning in the community and must meet criteria under any of one of the six categories (I-VI) below, and (3) provide evidence that proposed interventions are focused on the impairment identified above.

I) Client must meet DSM IV 5-Axis Mental Health Diagnosis Criteria for ***Medical Necessity***.
- ☐ Must be diagnosed by the MHP with an included DSM IV 5-Axis Mental Health Diagnosis

II) Client must meet Impairment Criteria for ***Service Necessity*** Substantial functional impairment in at least one of the following area:

A) ☐ Any child who is eligible for mental health service pursuant to Chapter 26.5 of the California Government Code [AB 3632].

B) At least one of the following:
- ☐ Referred for treatment in State Hospital or presently a patient in State Hospital or former patient in State Hospital transitioning to community living.
- ☐ In acute care hospital or former patient in an acute care hospital transitioning to the community.
- ☐ At risk of placement in an RCL Level 13 or 14 facility.
- ☐ Presently in a RCL level 13 or 14 facility or recently discharged from such a facility and transitioning to a lower level of care.
- ☐ Referred by Child and Family Services (CFS) for assessment only regarding out-of-home placement in the least restrictive setting, return from placement, or family reunification.

C) A child 5 years old or younger either:
- ☐ Displays severe delays in psychosocial and/or developmental milestones not the result of a developmental disability.

OR

- ☐ Is at risk for major psychosocial delay and the result of Mental Health Evaluation indicates significant deficits in at least one of the following areas: emotional, interpersonal, and behavioral.

OR

- ☐ Without Mental Health intervention, the child is at risk of being removed from their home

D) Children, of any age displaying:
- ☐ At least one of the following: (Level 5 – Child and Adolescent Problem Rating Scale)
- ☐ Persistent danger of hurting self and others.
- ☐ Serious suicidal act/rumination/plan with clear expectations of death.
- ☐ Behavior considerably influenced by delusions or hallucinations,
- ☐ Stressors: Catastrophic
- ☐ GAF: 0-30

III) OR

E) At least 3 of the following: (Level 4 – Child and Adolescent Problem Rating Scale)
- ☐ Behavior threatening or dangerous to self or others in past 3 months.
- ☐ Significant impairment in family, school, self maintenance or interpersonal relationships.
- ☐ Threat of or recent removal from home or placement.
- ☐ Recent release from psychiatric inpatient care.
- ☐ History of past hospitalization with risk of re-hospitalization.
- ☐ Stressors: Extreme
- ☐ GAF: 31-50

OR

F) At least 4 of the following: (Level 3 – Child and Adolescent Problem Rating Scale)
- ☐ History of dangerous behavior to self or others in past year.
- ☐ History of runaway, extended truancy.
- ☐ Acting out or avoidant, isolative behaviors at school and community.
- ☐ At risk for higher levels of care.
- ☐ History of past hospitalization with risk of re-hospitalization.
- ☐ Minimally adequate psychological support.
- ☐ Significant impairment in at least 2 of the following: family, school, self maintenance or interpersonal relationships.
- ☐ Clinically significant and persistent anxiety or mood symptoms.
- ☐ Stressors: Severe
- ☐ GAF: 51-65

OR

G) ☐ Children or adolescents who have previously met the above criteria and, who are presently in individual, group, and/or family therapy, and who no longer meet the above criteria may receive up to an additional 26 sessions of therapy if necessary for maintenance and continued stabilization.

IV) At least one of the following (Medication Support Services Only):
- ☐ Child: Children whose mental disorder is in full or partial remission may continue to receive medication support services in order to maintain the remission.
- ☐ Parent: If a child meets criteria under I, II, III, or IV above and the parent or primary caretaker requires medication support services to stabilize the home situation and to prevent out-of-home placement of the child, such services may be provided.

V) Any parent, guardian, or primary caregiver of a child 5 years old or younger who has a primary DSM AXIS I diagnosis of mental illness other than substance abuse or developmental disability which significantly disrupts or interferes with daily activity and either of the following (1 or 2) is present:
At least one of the following:
- ☐ Persistent danger of hurting self and others.
- ☐ Serious suicidal act/rumination/plan with clear expectations of death.
- ☐ Behavior considerably influenced by delusions or hallucinations,
- ☐ Due to a mental illness, is receiving or in need of medication to stabilize and maintain level of functioning in the community.

OR

VI) At least two of the following are present:
- ☐ Behavior threatening or dangerous to self or others in past 3 months.
- ☐ Significant impairment in ability to meet basic physical needs or to utilize resources for food, clothing, or shelter for self and children.
- ☐ Significant impairment in ability to meet basic psychological needs for self and child(ren) displaying severe delays in developmental milestones or a significant impairment in child(ren)'s self maintenance or family/school functioning.
- ☐ Threat of or recent removal of child(ren) from their care.
- ☐ Inadequate psychological and or psychosocial support system.
- ☐ Recent release from psychiatric inpatient service.
- ☐ History of past hospitalization with risk of re-hospitalization.

III) Client must meet Intervention Criteria for ***Service Necessity***. (Must have all 1,2, and 3)

A) The focus of the proposed intervention is to address the condition identified in the Impairment Criteria.
- ☐ Primary Goal of Partnership Plan outlines proposed interventions which address the condition of impairment.

AND

B) The expectation is that the proposed intervention will:
- ☐ Benefit from the proposed interventions by diminishing the impairment or preventing significant deterioration
- ☐ It is probably that the child will progress developmentally as individually appropriate
- ☐ If covered by EPSDT can be corrected or ameliorated.

AND

☐ The condition would not be responsive to physical health care-based treatment

Signature/Title: _____

Date: _____

(Template for treatment consent)

- SAMPLE -

Informed Consent for Treatment

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by _____ _____ (name of provider), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature _____ Date _____

Relationship to Patient (if applicable):_____

-SAMPLE-

(Template for treatment consent for a minor)

CONSENT TO TREATMENT FOR A CHILD

Name of Child Client _____

The therapist named below and I have discussed my child's situation. I have been informed of the risks and benefits of several different treatment choices. The treatment chosen includes these actions and methods:

1.
2.
3.

These actions and methods are for the purposes of:

1.
2.
3.

I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, as he or she sees fit) permission to begin this treatment as shown by my signature below.

_____ _____

Signature of Parent/Guardian Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____ _____

Signature of therapist Date

Abella Yose Care Service, Inc.
Behavior Analyst Daily Service Log

Name of Recipient:_____ **Case #:**_____ ID#: ON FILE

Venue (Mark all that applies): ☐ Home ☐ Community ☐ ADT ☐ Group Home

Other: _____

Work with: Client___ Parents___ Caregiver____ Behavior assistant ____ Other_____

Date of Service	Time In-Time Out	Units Provided	Name/Title Staff	Name of Person Providing Services/License#

Environmental changes: _____

Explain: _____

_____

Brief summary of behavior service provided (Marks all that apply)

Direct services	Indirect services
____ Functional Behavior Assessment/Brief Functional Analysis ____ Reinforcement Survey/Stimulus Preference Assessment ____ Direct observation/Data collection/Probing ____ Observation & feedback regarding interaction of parent, caregiver, BA, and others with recipient ____ Behavior Assistant training and supervision ____ Replacement Behavior Implementation ____ Acquisition Programs Implementation ____ Generalization of Treatment ____ Competency Check of Caregiver/Behavior Assistant ____ In-Service Education Training ____ Other _____	____ Professional consultation/Treatment Team Meeting/oversight /clinical direction ____ Monthly Progress Report/Data Analysis/Graphing ____ Annual Review (Waiver) ____ Behavior Plan Development/ Reviews (Waiver) ____ Task List/Goal Development (Acquisition & Replacement) ____ Assessment/Reassessment ____ Other _____

Client's Participation: ☐ Good ☐ Fair ☐ Poor ☐

Other/Comments: _____

Client was (circle): happy- joyful- uncomfortable- distracted –agitated- restless- uncooperative- cooperative careless- inattentive- attentive-stressed-depressed-grieving

Evidenced by_____

Validations: Previous agreement for times and place of next visit: ☐ Y or ☐ N

Next schedule Date/Place: _____

Behavior analyst signature and credential _____

FEELING DATA COLLECTION

NAME _____ DATE _____ DOB _____

CLIENT ID # _____ BEHAVIORAL THERAPIST NAME _____

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and circle the number which best describes your current situation. Circle only one number for each question and do not skip any. If you want to change an answer, please "x" it out and circle the correct one.

Never	Rarely	Sometimes	Frequently	Almost Always		
0	1	2	3	4	1.	I get along well with others.
0	1	2	3	4	2.	I tire quickly.
0	1	2	3	4	3.	I feel no interest in things.
0	1	2	3	4	4.	I feel stressed at work/school.
0	1	2	3	4	5.	I blame myself for things.
0	1	2	3	4	6.	I feel irritated.
0	1	2	3	4	7.	I feel unhappy in my marriage/significant relationship.
0	1	2	3	4	8.	I have thoughts of ending my life.
0	1	2	3	4	9.	I feel weak.
0	1	2	3	4	10.	I feel fearful.
0	1	2	3	4	11.	After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark "never").
0	1	2	3	4	12.	I find my work/school satisfying.
0	1	2	3	4	13.	I am a happy person.
0	1	2	3	4	14.	I work/study too much.
0	1	2	3	4	15.	I feel worthless.
0	1	2	3	4	16.	I am concerned about family troubles.
0	1	2	3	4	17.	I have an unfulfilling sex life.
0	1	2	3	4	18.	I feel lonely.
0	1	2	3	4	19.	I have frequent arguments.
0	1	2	3	4	20.	I feel loved and wanted.
0	1	2	3	4	21.	I enjoy my spare time.
0	1	2	3	4	22.	I have difficulty concentrating.
0	1	2	3	4	23.	I feel hopeless about the future.
0	1	2	3	4	24.	I like myself.
0	1	2	3	4	25.	Disturbing thoughts come into my mind that I cannot get rid of.
0	1	2	3	4	26.	I feel annoyed by people who criticize my drinking (or drug use) (if not applicable, mark "never").
0	1	2	3	4	27.	I have an upset stomach.
0	1	2	3	4	28.	I am not working/studying as well as I used to.
0	1	2	3	4	29.	My heart pounds too much.
0	1	2	3	4	30.	I have trouble getting along with friends and close acquaintances.
0	1	2	3	4	31.	I am satisfied with my life.
0	1	2	3	4	32.	I have trouble at work/school because of my drinking or drug use (if not applicable, mark "never").
0	1	2	3	4	33.	I feel that something bad is going to happen.
0	1	2	3	4	34.	I have sore muscles.
0	1	2	3	4	35.	I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
0	1	2	3	4	36.	I feel nervous.
0	1	2	3	4	37.	I feel my love relationships are full and complete.
0	1	2	3	4	38.	I feel that I am not doing well at work/school.
0	1	2	3	4	39.	I have too many disagreements at work/school.
0	1	2	3	4	40.	I feel something is wrong with my mind.
0	1	2	3	4	41.	I have trouble falling asleep or staying asleep.
0	1	2	3	4	42.	I feel blue.
0	1	2	3	4	43.	I am satisfied with my relationships with others.
0	1	2	3	4	44.	I feel angry enough at work/school to do something I might regret.
0	1	2	3	4	45.	I have headaches.

NAME
MR#
DOB

MENTAL HEALTH DIVISION

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

NAME OF MEDICATION:
The specific medication being prescribed is: _____

PRIMARY REASON FOR THIS MEDICATION:
This medication is intended to help you (or your child) with the following specific problem or symptoms:

_____

This medication is in the class:
☐ Antipsychotic ☐ Antidepressant ☐ Mood Stabilizer
☐ Psycho-stimulant ☐ Anti-Anxiety ☐ OTHER (specify): _____

You (your child) will begin taking _____ mg of this medicine _____ times per day,
ADMINISTERED: ☐ by mouth ☐ by injection
and the dose may be increased over time, but only as recommended by the doctor.
For you (your child), the projected maximum daily dose is _____ mg per day, divided into _____ doses per day.

ALTERNATIVES: Alternatives to the use of this medication for your (or your child's) condition include:
☐ Psychotherapy ☐ Other medication ☐ Family Therapy ☐ Group Therapy ☐ Other: _____

Without such medication:
☐ Your (child's) condition is likely to worsen.
☐ Your (child's) condition is unlikely to improve.
☐ Your (child's) condition may or may not improve.
☐ Your (child's) condition is likely to improve.
☐ Your (child's) condition is likely to recur.

GENERAL PRECAUTIONS REGARDING PSYCHOTROPIC MEDICATIONS

- Avoid the use of alcoholic beverages while taking any psychiatric medication.
- All psychiatric medications, including this one, may cause birth defects. Please inform your doctor if you are pregnant or planning to get pregnant.
- Please inform your doctor is you are breastfeeding or plan to breastfeed.
- Please inform your doctor of all medicines you are currently taking (including over-the-counter & herbal).
- Do not share this medicine with others for whom it was not prescribed.
- Keep this medicine out of the reach of children.
- This Information Sheet may not cover all uses or side effects of this medication.

I have received and have had an opportunity to review with the doctor a Medication Information Sheet, describing the specific benefits and side effects of this medicine. ***Patient/Guardian initial:*** _____

I hereby give my consent to treatment with this medication. I understand that I may seek additional information, and that I may withdraw consent at any time by stating my intention to any member of the treatment team.

_____ _____
Signature of Patient/Parent/Guardian/Conservator; DATE Signature/Licensure of Prescribing Physician; DATE

Progress Note/ Billing Form

Behavioral Health Division

NAME / MRN

Service Date: _____ RU: _____

Staff #:_____ Hours* _____ Mins _____ # in Group: _____

Co-Staff #: _____ Hours* _____ Mins _____ Total Travel Time: Hours _____ Mins _____

*** Service duration must include travel time, if applicable**

Services: (Check one)

☐ **300** No Show	☐ **313** Evaluation	☐ **351** Group Therapy	☐ **571** Case Mgmt - Plan Develpmt
☐ **400** Client Cancel	☐ **315** Plan Develpmt	☐ **355** Group Rehab	☐ **540** Non-Billable Services
☐ **700** Staff Cancel	☐ **317** Rehab	☐ **357** Group Collateral	☐ **580** Non-Billable - Lock-outs
☐ **371** Crisis Int.	☐ **331** Assessment	☐ **541** Case Mgmt - Placement	
☐ **311** Collateral	☐ **341** Indiv Therapy	☐ **561** Case Mgmt - Linkage	

Location of Services: (Check one)

☐ **1** Office	☐ **5** School	☐ **11** Faith-based	☐ **15** Licensed Care Fac. (Adult)	☐ **19** Residential Tx Center (Child)
☐ **2** Field	☐ **8** Correctional Facility	☐ **12** Healthcare	☐ **16** Mobile Service	
☐ **3** Phone	☐ **9** Inpatient	☐ **13** Age-Specific Center	☐ **17** Non-Traditional Location	☐ **20** Telehealth
☐ **4** Home	☐ **10** Homeless/Shelter	☐ **14** Client's Job-site	☐ **18** Other	☐ **21** Unknown

Service Strategies: (Check up to three, if applicable)

☐ **50** Peer/Family Services	☐ **53** Supportive Education	☐ **56** With Social Services	☐ **59** With Develpmt Disabled
☐ **51** Psycho-Education	☐ **54** With Law Enforcement	☐ **57** With Substance Abuse	☐ **60** Ethnic-specific Services
☐ **52** Family Support	☐ **55** With Health Care	☐ **58** With Aging Providers	☐ **61** Age-specific Services
			☐ **99** Unknown

Is the client pregnant? ☐ **Yes** ☐ **No** **(If yes, please document how service was pregnancy-related)**

☐ **Interpreter** **Name of Interpreter:** _____

Language service provided in other than English: ☐ **Spanish** ☐ **Other**_____

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

_____

_____

1b. Description of Current Situation/Reason for Contact:
(Status update, needs, clinical impressions)

Current DSM Diagnosis __ __ __.__ __

_____

_____

_____

_____

_____

_____

Name: _____ MRN: _____

2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) *Specify what the consumer/family/providers are to do.*

Signature/License/Job Title | Printed Name | Date

Co-Signature/License (if applicable) | Date

Computer Entry Clerk Initials

Abella Yose Care Service, Inc.

INDEPENDENT CONTRACT INVOICE

Registered Behavior Technician (RBT) / Behavior Assistant (BA)

Month: _____ Year: _____

No	Client's Name	Hours Worked	Office Use	Office Use

Total hours: _____

IC Name: _____ IC Signature: _____ Date: _____

Check payable to: _____ Please circle: Direct deposit / Check

* if check payable to a corporation, please write the name above

NAME
MR#
DOB

MENTAL HEALTH DIVISION

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

NAME OF MEDICATION:
The specific medication being prescribed is: _____

PRIMARY REASON FOR THIS MEDICATION:
This medication is intended to help you (or your child) with the following specific problem or symptoms:

_____

This medication is in the class:
☐ Antipsychotic ☐ Antidepressant ☐ Mood Stabilizer
☐ Psycho-stimulant ☐ Anti-Anxiety ☐ OTHER (specify): _____

You (your child) will begin taking _____ mg of this medicine _____ times per day,
ADMINISTERED: ☐ by mouth ☐ by injection
and the dose may be increased over time, but only as recommended by the doctor.
For you (your child), the projected maximum daily dose is _____ mg per day, divided into _____ doses per day.

ALTERNATIVES: Alternatives to the use of this medication for your (or your child's) condition include:
☐ Psychotherapy ☐ Other medication ☐ Family Therapy ☐ Group Therapy ☐ Other: _____

Without such medication:
☐ Your (child's) condition is likely to worsen.
☐ Your (child's) condition is unlikely to improve.
☐ Your (child's) condition may or may not improve.
☐ Your (child's) condition is likely to improve.
☐ Your (child's) condition is likely to recur.

GENERAL PRECAUTIONS REGARDING PSYCHOTROPIC MEDICATIONS

- Avoid the use of alcoholic beverages while taking any psychiatric medication.
- All psychiatric medications, including this one, may cause birth defects. Please inform your doctor if you are pregnant or planning to get pregnant.
- Please inform your doctor is you are breastfeeding or plan to breastfeed.
- Please inform your doctor of all medicines you are currently taking (including over-the-counter & herbal).
- Do not share this medicine with others for whom it was not prescribed.
- Keep this medicine out of the reach of children.
- This Information Sheet may not cover all uses or side effects of this medication.

I have received and have had an opportunity to review with the doctor a Medication Information Sheet, describing the specific benefits and side effects of this medicine. ***Patient/Guardian initial:*** _____

I hereby give my consent to treatment with this medication. I understand that I may seek additional information, and that I may withdraw consent at any time by stating my intention to any member of the treatment team.

_____ _____
Signature of Patient/Parent/Guardian/Conservator; DATE Signature/Licensure of Prescribing Physician; DATE

NAME/MRN:

BEHAVIORAL HEALTH DIVISION

INITIAL PSYCHIATRIC ASSESSMENT

DATE OF SERVICE _____ RU# _____

STAFF # _____ HOURS _____ MINUTES _____

Code Activity: ☒361 EVAL/RX Location: ☐ 1 Office ☐ 2 Field ☐ 4 Home ☐ 5 School Satellite ☐ 18 Other

Service Strategies: (Please check up to three, if applicable)

☐ **50** Peer/Fam Deliv Svcs	☐ **53** Supportive Education	☐ **56** Ptnrshp:Soc Svcs	☐ **59** Integrated Svcs:MH-Dvlp Disbled
☐ **51** Psych Education	☐ **54** Prtnrshp:LawEnfcmt	☐ **57** Ptnrshp:Subs Abuse	☐ **60** Ethnic-Specific Service Strategy
☐ **52** Family Support	☐ **55** Ptnrshp:Health Care	☐ **58** IntSvcs:MH/Aging	☐ **61** Age-Spec Svc Strategy ☐ **99** Unknown

Assessment in language other than English: ☐ Spanish ☐ Other _____

☐ Interpreter Name of Interpreter: _____

Identifying Information:

Legal Name: _____ DOB/Age:_____

Preferred Name: _____

Gender: ☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Separated ☐ Divorced

Address: _____ Phone #: _____

Emergency Contact / Significant Other: _____ _____

Name Phone

Primary concerns per consumer: _____

_____

Presenting Problem/ Recent Course of Illness: _____

_____

_____

_____

_____

_____

_____

_____

Consumer and Family Strengths (Positive factors to facilitate treatment e.g. faith, resilience, etc.):

_____

_____

_____

NAME/MRN

Psychiatric History (include hospitalizations and dates, suicide attempts, history of intervention):

_____

_____

_____

_____

_____

Psychiatric Medication History (Current and Past, side effects, adherences & outcomes) Current: ☐None Past: ☐None

_____

_____

_____

_____

Alcohol/ Drug Use History: (Check all appropriate and provide details.)

☐Unknown ☐No Current Substance Abuse ☐No Past Substance Abuse ☐Currently Clean & Sober for: ☐>3 Mos. ☐>1 Yr

Alcohol	☐ Past	☐ Present	Nicotine	☐ Past	☐ Present	Caffeine	☐ Past	☐ Present
Cocaine	☐ Past	☐ Present	Marijuana	☐ Past	☐ Present	Amphetamines	☐ Past	☐ Present
Opiates	☐ Past	☐ Present	Ecstasy	☐ Past	☐ Present	Hallucinogens	☐ Past	☐ Present
Sedatives	☐ Past	☐ Present	Inhalants	☐ Past	☐ Present	Energy Drinks	☐ Past	☐ Present
Other:	☐ Past	☐ Present	Specify: _____					

_____

Medical History (include illnesses, surgeries, CNS, head injuries):

Date of Last Physical: _____ Physician(s)/clinic: _____ Phone #: _____

Weight: _____ Height: _____ BMI: _____

Allergies (Meds & Other) / Adverse Reaction: _____

Active Medical Concerns, History of Hospitalizations/Surgeries: _____

Non-Psych Med/OTC _____

Review of Systems: ☐ No Significant issues revealed

☐ CV ☐ Renal ☐ GI ☐ Hepatic ☐ CNS ☐ GU ☐ Metabolic ☐ CA ☐ PULM ☐ Gyn ☐ ID/HIV

☐ Sexually Active Contraceptive Method _____ ☐ Risk of Pregnancy ☐ Pregnant

☐ Breast-Feeding LMP: _____

Pregnancy and Birth History (<18):_____

Developmental History (<18): _____

NAME/MRN

Family Psychiatric History:

_____

_____

Psychosocial History (e.g. education, family, vocational, military, legal):

_____

_____

_____

_____

Psychosocial Risk Factors: (Check all that apply.) Document details.

☐ Victim of Physical Abuse	☐ History of Self-injurious Behavior
☐ Victim of Sexual Abuse	☐ History of Suicidal Behavior
☐ Trauma or Loss in the Family	☐ Family History of Suicide
☐ Domestic Violence: Victim ☐ Perpetrator ☐	☐ Access to Firearms (family, friends, self)
☐ History of Substance Abuse	☐ Access to Other Means of Suicide
☐ History of Assaultive Behavior	☐ Lack of Social Support
☐ History of Threatening Behavior	☐ History of Foster Care
☐ History of Inappropriate Sexual Behavior	☐ Homelessness
☐ Behavior Influences by Delusions or Hallucinations	☐ Other

Comments:

MENTAL STATUS EXAMINATION

APPEARANCE/GROOMING	☐ Unremarkable	☐ Remarkable for:
PSYCHO-MOTOR ACTIVITY	☐ Unremarkable	☐ Remarkable for:
ATTITUDE/RELATEDNESS	☐ Unremarkable	☐ Remarkable for:
SPEECH	☐ Unremarkable	☐ Remarkable for:
MOOD	☐ Unremarkable	☐ Remarkable for:
AFFECT	☐ Unremarkable	☐ Remarkable for:
THOUGHT PROCESS	☐ Unremarkable	☐ Remarkable for:
THOUGHT CONTENT	☐ Unremarkable	☐ Remarkable for:
PERCEPTUAL DISTURBANCE	☐ Unremarkable	☐ Remarkable for:
ORIENTATION	☐ Unremarkable	☐ Remarkable for:
MEMORY/CONCENTRATION	☐ Unremarkable	☐ Remarkable for:
FUND OF KNOWLEDGE	☐ Unremarkable	☐ Remarkable for:
INTELLECT/ABSTRACT THINKING	☐ Unremarkable	☐ Remarkable for:
INSIGHT/ JUDGEMENT	☐ Unremarkable	☐ Remarkable for:
IMPULSE CONTROL	☐ Unremarkable	☐ Remarkable for:

Additional Observations: _____

NAME/MRN

Current Risk Assessment:

Danger to SELF (Intent, Plan Means): _____

Danger to OTHER (Intent, Plan Means): _____

Grave Disability: _____

Clinical Summary (Optional):

_____

_____

_____

_____

_____

_____

Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a "P"

Axis I _____ p / s _____
Axis I _____ p / s _____
Axis I _____ _____
Axis II _____ p / s _____ ☐ V71.09 ☐ 799.9

Axis III _____ Check If None ☐

Axis IV **CONTRIBUTING STRESSORS – Problems related to:**

☐ **A** – Primary Support ☐ **B** – Social Environment ☐ **C** – Education ☐ **D** – Occupation ☐ **E** – Housing
☐ **F** – Economic ☐ **G** – Access to Health Care ☐ **H** – Legal System ☐ **I** – Other/ System/ War

Axis V **CURRENT GAF:** _____ **HIGHEST GAF PAST YEAR:** _____

FUNCTIONAL IMPAIRMENT: (IF MODERATE OR ABOVE, MAY WARRANTS TARGETED CASE MANAGEMENT)

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	**Peer Relations**	☐	☐	☐	☐
Academic/Vocational Performance	☐	☐	☐	☐	**Physical Health**	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	**Substance Abuse**	☐	☐	☐	☐

TARGETED SYMPTOMS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	**Perceptual Disturbance**	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	**Antisocial Behavior**	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	**Destructive/Assaultive**	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	**Mania/Agitation/Lability**	☐	☐	☐	☐
Anxiety/Phobia/Panic Attack	☐	☐	☐	☐	**Somatic Disturbance**	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	**Other**_____	☐	☐	☐	☐

NAME/MRN

Initial Treatment Plan/Targeted Case Management:

Does consumer meet the criteria for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, need for financial support, social support, prevocational/employment assistance, rehabilitation, AOD services, or other programs or services considered necessary.) ☐ No ☐ Yes

Explain: _____

_____

_____

Referral to Coordination of Care with:

☐ PCP ☐ Case Management ☐ Therapist ☐ Family/ Other Support ☐ Substance Abuse Tx ☐ Housing

☐ Community Agencies ☐ Vocational Rehab ☐ Social Security

Details: _____

Labs Ordered: _____

_____

Medications Prescribed / Dosage / Frequency:

_____

_____

_____

_____

☐ Drug Information Sheet for each medication was given to consumer and family.
☐ Benefits/Risks/Possible adverse effects of medication and Alternatives to medication have been discussed.
☐ An opportunity was given to ask questions.
☐ The consumer and/or family appear to understand the information on the form.
☐ If appropriate, discuss the interaction of psychiatric medication with the following: Pregnancy, Lactation, Alcohol, Nutrition, and Non-Psychiatric Medications
☐ An Informed Consent was signed within the past two years.

Consumer (Family) is able to manage own medication: ☐ Yes ☐ No

If not, explain:

_____

Additional Information:

_____

_____

_____

_____

MD/DO/NP Signature: _____ Date: _____

PRINT FULL NAME AND TITLE _____

_____
Data Entry Clerk Initials

NAME/MRN:

MENTAL HEALTH DIVISION

PSYCHIATRIC ASSESSMENT ANNUAL UPDATE

DATE OF SERVICE: _____ RU#: _____

STAFF #: _____ HOURS: _____ MINUTES: _____

Code: ☐ 361EVAL/RX Location: ☐ 1 Office ☐ 2 Field ☐ 4 Home ☐ 5 School ☐ 10 Shelter

☐ 364 PLAN/DEV Service Strategies: (Please mark up to three, if applicable)

☐ **50** Peer/Fam Deliv Svcs	☐ **53** Supportive Education	☐ **56** Ptnrshp:Soc Svcs	☐ **59** Integrated Svcs:MH-Dvlp Disbled
☐ **51** Psych Education	☐ **54** Prtnrshp:LawEnfcmt	☐ **57** Ptnrshp:Subs Abuse	☐ **60** Ethnic-Specific Service Strategy
☐ **52** Family Support	☐ **55** Ptnrshp:Health Care	☐ **58** IntSvcs:MH/Aging	☐ **61** Age-Spec Svc Strategy ☐ **99** Unknown

Description and Interim Psychiatric Treatment History (since last assessment): _____

MENTAL STATUS EXAMINATION

General (e.g., appearance, behavior) _____

Mood/Affect _____

Perception _____

Thinking _____

Insight /Judgment _____

Cognitive ☐ WNL _____

Allergies or Adverse Reactions/Drug Intolerances: ☐ NKA

Reviewed and Discussed: ☐ Pregnancy Risk ☐ Current Substance ☐ Current Suicide Risk

Details: _____

NAME/MRN

DIAGNOSIS: (Circle primary/secondary, p / s). Include substance related.

Axis I _____ p / s _____

Axis I _____ p / s _____

Axis I _____ _____

Axis II _____ p / s ☐ V71.09 ☐ 799.9 _____

Axis III ☐none _____

Axis IV Contributing Stressors, problems related to:

☐ A-Primary Support ☐ B-Social Environment ☐ C-Education ☐ D-Occupation ☐E-Housing

☐ F-Economic ☐ G-Access to Health Care ☐ H-Legal System ☐ I-Other/ System/ War

Axis V GAF: _____

Active Medical Problems: _____

_____

_____

_____

_____ PCP _____ Date of last visit _____

Current Psychiatric Medications: Current Non-Psychiatric Drugs (incl OTC & herbal):

_____ _____

_____ _____

_____ _____

_____ _____

Changes in Treatment/ Recovery Plan: _____

_____

_____

_____

☐ Treatment Plan/Partnership Plan signed by consumer.
☐ Drug information was provided and informed consent is current for each medication prescribed.
☐ The consumer appears to understand the information provided and was given opportunity to ask questions.

Consumer is able to manage own medication: ☐ YES ☐ NO Explain _____

_____

_____

Does client warrant the consideration for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, needed for financial support, social support, prevocational/employment assistance, rehabilitation, or other programs or services considered as necessary.) ☐ Yes ☐ No

Assessment in language other than English: ☐ Spanish ☐ Other_____

☐ Interpreter Name of Interpreter: _____

MD Signature: _____ **Date:** _____

Name/MRN

MENTAL HEALTH DIVISION

PSYCHIATRIC SERVICES PROGRESS NOTE/BILLING FORM

DATE OF SERVICE _____ RU# _____ # IN GROUP _____

STAFF # _____ HOURS _____ MINUTES _____

CO-STAFF# _____ HOURS _____ MINUTES _____

TRAVEL TIME: Hrs _____ Minutes _____

	Med Svcs		MH Services	CM and Non-Billable Services
	☐ **300** No Show	☐ **362** RN/INJ	☐ **311** Collateral	☐ **541** Case Mgmt - Placement
	☐ **400** Client Cancel	☐ **363** EDUC	☐ **341** Indiv Therapy	☐ **561** Case Mgmt - Linkage
	☐ **700** Staff Cancel	☐ **364** PLAN/DEV	☐ **351** Group Therapy	☐ **540** Non-Billable - MH Services
	☐ **361** EVAL/RX	☐ **369** MED GROUP	☐ **371** Crisis Intervention	☐ **580** Non-Billable - Lock-outs
Loc	☐ **1** Office	☐ **3** Phone	☐ **5** School	☐ **9** Inpatient
	☐ **2** Field	☐ **4** Home	☐ **8** Correctional Facility	☐ **18** Other
Svc Stgy	☐ **50** Peer/Family Services	☐ **53** Supportive Education	☐ **56** With Social Services	☐ **59** With Developmentally Disabled
	☐ **51** Psycho-Education	☐ **54** With Law Enforcement	☐ **57** With Substance Abuse	☐ **60** Ethnic-specific Services
	☐ **52** Family Support	☐ **55** With Health Care	☐ **58** With Aging Providers	☐ **61** Age-specific Services

BRIEF DESCRIPTION OF CLIENT ***(Age, Gender, Current Presentation, Date of Last Visit):***

☐ **Interpreter** Name of Interpreter**:** _____

Language service provided in other than English: ☐ Spanish ☐ Other_____

INTERIM HISTORY AND OBSERVATIONS

(Progress and Improvement, Current and/or Persistent and/or Symptoms/Problems/Issues):

TARGETED MENTAL STATUS EXAM ***(Orientation, grooming, mood, affect, thought/perceptual content, insight)*****:**

Partnership Plan for Wellness: Adult Services (Physicians and RNs)

This plan is to describe my treatment goals and responsibilities.
My psychiatrist and I will work on this plan together and review these goals at least every 6 – 12 months.

My Strengths:

_____

_____

I will collaborate with my psychiatrist to minimize or eliminate my symptoms and to prevent or minimize medication side effects so that I may better live a life of my own choosing.

Specify goals for my treatment may include (√ *all appropriate boxes)*:

☐ To feel well
☐ To find meaningful and satisfying work
☐ To become more self-reliant and/or live independently
☐ To enjoy a better social life
☐ To go to school or get training
☐ To avoid the need for hospitalization
☐ To better understand the potential benefits, risks and side effects of my medication.
☐ To understand my treatment options including other medications and alternatives to medication.
☐ Easily identify steps to improve my health at each visit so my treatment is safe, specific and effective.
☐ I will be able to recognize side effects of my medications or other concerns I might have regarding my treatment.
☐ Achieve and maintain sobriety
☐ Take my medication as prescribed.
☐ Attend appointments with my psychiatrist regularly.
☐ I will discuss with my psychiatrist whenever I engage in self-harmful activities.

Additional goals for my treatment:

_____

_____

_____

_____

_____

(Continued on page 2)

Strategies to achieve goals:

- ☐ I will understand and be able to describe at each visit, the potential benefits, risks, and side effects of my medications, or other concerns I have regarding treatment.
- ☐ I will understand my treatment options, including other medications and alternatives to medications and discuss them with my psychiatrist at each visit.
- ☐ I will identify and discuss different steps to improve my health at each visit so that my treatment is safe, specific, and effective.
- ☐ I will take my medication as prescribed and report to my psychiatrist at each visit the difficulty I have doing so.
- ☐ I will attend all of my appointments with my psychiatrist.
- ☐ I will attend monthly medication support group (if available).
- ☐ I will discuss with my psychiatrist whenever I engage in self-harmful activities and discuss strategies to prevent such activities.
- ☐ I will identify stressors or events that trigger a crisis and discuss with my psychiatrist at each visit, stressors as they come up.
- ☐ I will discuss with my psychiatrist, any and all behavioral health conditions, challenges and my recovery process.
- ☐ I will participate in the recovery process to achieve and maintain clean and sober living.

I can help my own treatment by learning about self-care recovery strategies and developing a trusting relationship with my doctor. It is important for me to feel comfortable talking with my doctor about changes in symptoms, concerns about my medications, and any side effects that I experience.

My signature on this plan indicates my participation in discussion about its contents.

_____ _____

Consumer and/or Representative's Signature* Date Psychiatrist/RN Signature Date

On_____, Consumer was offered and: ☐ **received** ☐ **declined** a copy of Partnership Plan.
Date

**If no signature, see progress note dated:* _____

Goals for my treatment added or changed after signature above: (Please date additions or changes.)

_____

_____

_____

My signature indicates my participation in discussion about these additions or changes to this plan.

_____ _____

Consumer/Representative's Signature* Date Psychiatrist/RN Signature Date

On_____, Consumer was offered and: ☐ **received** ☐ **declined** a copy of amended Partnership Plan. **If no signature, see progress note dated:* _____

_____

Auth. Committee Signature Date

MRN/LAST NAME

CURRENT MEDICATIONS: ***Please list all Psychiatric and non-Psychiatric medications at each visit.***

☐ ***Medication Consents are current*** ☐ ***Adherence / Side Effects / Adverse Effects Discussed***

OBJECTIVE DATA: *Lab or other Studies Reviewed:* ☐ *AIMS Performed:* ☐ *Ht____Wt ____BMI____Waist_____BP/P_____*

Results:

CURRENT DIAGNOSTIC IMPRESSION ***(DSM DXS plus status):***

DESCRIPTION OF PSYCHOTHERAPEUTIC INTERVENTION, IF ANY:

PLAN FOR CONTINUED SERVICE: *(INCLUDING LAB ORDERS, EDUCATION, COORDINATION OF CARE).*

LABS/ Other Studies ordered: ☐ ***REFERRAL to PCP*** ☐ ***REFERRAL for Psychotherapy*** ☐ ***Coordination with PCP*** ☐

℞: ☐ **No ℞ Changes** **# Refills Authorized _____** ☐ **Medication Record Updated**
☐ **Medication Changes and Rationale** ☐ **Justification of Continued Use of Benzodiapines**

SPECIFIC CHANGES:

Next Appt: w/ MD/DO_____ **w/ RN**_____ **w/ Case Manager/Other**_____

MD/DO/NP Signature: _____ DATE: _____

MD/DO/NP NAME: _____

For office use only
CLERICAL STAFF INITIALS
_____

Partnership Plan For Wellness
Children's Services
(Physicians and RNs)

This plan is to describe the treatment goals and responsibilities for my child and family.
My (foster) child's psychiatrist, my (foster) child, and I will work on this plan together and review these goals at least every 6 – 12 months.

My Child's/Family Strengths:

_____

_____

We will collaborate with our psychiatrist to minimize or eliminate symptoms and to prevent or minimize medication side effects so that my child may better live like others the same age.

Specify goals for my child's treatment may include (√ *all appropriate boxes)*:

- ☐ To feel well
- ☐ To achieve a healthy living environment at home
- ☐ To gain skills that promote independence
- ☐ To fully participate in sports/arts/community activities
- ☐ To enjoy a better social life
- ☐ To do well in school
- ☐ To avoid the need for hospitalization

Additional goals for my child's treatment:

_____

_____

_____

_____

_____

Strategies we will use to achieve Goals –

- ☐ We will discuss my child's behavioral challenges and conditions.
- ☐ We will understand and be able to describe at each visit, the potential benefits, risks, and side effects of my child's medications.
- ☐ We will understand treatment options, including other medications and alternatives to medications and discuss them with the psychiatrist at each visit.
- ☐ We will identify and discuss different steps to improve my child's health at each visit so that my child's treatment is safe, specific, and effective.
- ☐ We will recognize and discuss at each visit, side effects of my child's medications or other concerns my child or I might have regarding my child's treatment.

(Continued on page 2)

☐ My child will take any medication as prescribed and report to the psychiatrist at each visit any difficulty in doing so.

☐ We both will attend all of our appointments with the psychiatrist.

☐ My child and/or I will attend monthly medication support group.

☐ My child and I will discuss with the psychiatrist whenever my child engages in self-harmful activities and discuss strategies to prevent such activities.

☐ My child and I will identify 3 stressors or events that trigger a crisis and discuss with the psychiatrist at each visit, stressors as they come up.

I can help my child's treatment by developing a trusting relationship with the psychiatrist. It is important for both my child and me to feel comfortable talking with my child's doctor about changes in symptoms, concerns about medications, and any side effects that my child experiences.

My signature and my child's signature on this plan indicate our participation in discussion about its contents.

_____ _____

Parent/Foster Parent's Signature* Date Psychiatrist Signature Date

_____

Child/Adolescent's Signature Date

On_____, the parent was offered and: ☐ **received** ☐ **declined** a copy of Partnership Plan.

**If no signature, see progress note dated:* _____

Goals for this treatment added or changed after signature above: (Please date additions or changes.):

_____

_____

_____

_____

My signature and my child's signature on this plan indicate our participation in discussion about these additions or changes

_____ _____

Parent/Foster Parent's Signature* Date Psychiatrist Signature Date

_____

Child/Adolescent's Signature Date

On_____, the parent was offered and: ☐ **received** ☐ **declined** a copy of Partnership Plan.

**If no signature, see progress note dated:* _____

PSYCHIATRIC/BEHAVIORAL NURSING ASSESSMENT

☐ INITIAL ASSESSMENT
☐ RE-ASSESSMENT

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

PT. NAME_____ PT. #_____ HI #_____

CHECK (☑) BOX OR CIRCLE NUMBER FOR MOST APPROPRIATE ANSWER.
IF "NORMAL" IS CHECKED, GO TO NEXT SECTION.
IF NOT "NORMAL", RATE PERTINENT ITEMS ONLY.

1= MILD * 2 =MODERATE * **3** = SEVERE (Marked)

GENERAL APPEARANCE

— NORMAL ☐

FACIAL EXPRESSIONS:

SAD 1 2 3
EXPRESSIONLESS 1 2 3
HOSTILE 1 2 3
WORRIED 1 2 3
AVOIDS GAZE 1 2 3

DRESS:

METICULOUS 1 2 3
CLOTHING, HYGIENE POOR 1 2 3
ECCENTRIC 1 2 3
SEDUCTIVE 1 2 3
EXPOSED 1 2 3

MOTOR ACTIVITY

— NORMAL ☐

INCREASED AMOUNT 1 2 3
DECREASED AMOUNT 1 2 3
AGITATION 1 2 3
TICS 1 2 3
TREMOR 1 2 3
PECULIAR POSTURING 1 2 3
UNUSUAL GAIT 1 2 3
REPETITIVE ACTS 1 2 3

SPEECH

— NORMAL ☐

EXCESSIVE AMOUNT 1 2 3
REDUCED AMOUNT 1 2 3
SPEECH 1 2 3
SLOWED 1 2 3
LOUD 1 2 3
SOFT 1 2 3
MUTE 1 2 3
SLURRED 1 2 3
STUTTERING 1 2 3

INTERVIEW BEHAVIOR

— **NORMAL** ☐

ANGRY OUTBURSTS 1 2 3
IRRITABLE 1 2 3
IMPULSIVE 1 2 3
HOSTILE 1 2 3
SILLY 1 2 3
SENSITIVE 1 2 3
APATHETIC 1 2 3
WITHDRAWN 1 2 3
EVASIVE 1 2 3
PASSIVE 1 2 3
AGGRESSIVE 1 2 3
NAIVE 1 2 3
OVERLY DRAMATIC 1 2 3
MANIPULATIVE 1 2 3
DEPENDENT 1 2 3
UNCOOPERATIVE 1 2 3
DEMANDING 1 2 3
NEGATIVISTIC 1 2 3
CALLOUS 1 2 3
MOOD SWINGS 1 2 3

FLOW OF THOUGHT

— NORMAL ☐

BLOCKING 1 2 3
CIRCUMSTANTIAL 1 2 3
TANGENTIAL 1 2 3
PERSEVERATION 1 2 3
FLIGHT OF IDEAS 1 2 3
LOOSE ASSOCIATION 1 2 3
INDECISIVE 1 2 3

MOOD AND AFFECT

— NORMAL ☐

ANXIOUS 1 2 3
INAPPROPRIATE AFFECT 1 2 3
FLAT AFFECT 1 2 3
ELEVATED MOOD 1 2 3
DEPRESSED MOOD 1 2 3
LABILE MOOD 1 2 3

CONTENT OF THOUGHT

— NORMAL ☐

SUICIDAL THOUGHTS 1 2 3
SUICIDAL PLANS 1 2 3
ASSAULTIVE IDEAS 1 2 3
HOMICIDAL THOUGHTS 1 2 3
HOMICIDAL PLANS 1 2 3
ANTISOCIAL ATTITUDES 1 2 3
SUSPICIOUSNESS 1 2 3
POVERTY OF CONTENT 1 2 3
PHOBIAS 1 2 3
OBSESSIONS 1 2 3
COMPULSIONS 1 2 3
FEELINGS OF UNREALITY 1 2 3
FEELS PERSECUTED 1 2 3
THOUGHTS OF RUNNING AWAY.. 1 2 3
SOMATIC COMPLAINTS 1 2 3
IDEAS OF GUILT 1 2 3
IDEAS OF HOPELESSNESS 1 2 3
IDEAS OF WORTHLESSNESS ... 1 2 3
EXCESSIVE RELIGIOSITY 1 2 3
SEXUAL PREOCCUPATION 1 2 3
BLAMES OTHERS 1 2 3

ILLUSIONS:

PRESENT 1 2 3

HALLUCINATIONS:

AUDITORY 1 2 3
VISUAL 1 2 3
OTHER 1 2 3

DELUSIONS:

OF PERSECUTION 1 2 3
OF GRANDEUR 1 2 3
OF REFERENCE 1 2 3
OF INFLUENCE 1 2 3
SOMATIC 1 2 3
OTHER 1 2 3
ARE SYSTEMATIZED 1 2 3

SENSORIUM

— NORMAL ☐

ORIENTATION IMPAIRED

TIME 1 2 3
PLACE 1 2 3
PERSON 1 2 3

MEMORY

CLOUDING OF CONSCIOUSNESS 1 2 3
INABILITY TO CONCENTRATE .. 1 2 3
AMNESIA 1 2 3
POOR RECENT MEMORY 1 2 3
POOR REMOTE MEMORY 1 2 3
CONFABULATION 1 2 3

INTELLECT

— NORMAL ☐

ABOVE NORMAL 1 2 3
BELOW NORMAL 1 2 3
PAUCITY OF KNOWLEDGE 1 2 3
VOCABULARY POOR 1 2 3
SERIAL SEVENS DONE POORLY. 1 2 3
POOR ABSTRACTION 1 2 3

INSIGHT AND JUDGMENT

— **NORMAL** ☐

POOR INSIGHT 1 2 3
POOR JUDGMENT 1 2 3
UNREALISTIC REGARDING
DEGREE OF ILLNESS 1 2 3
DOESN'T KNOW WHY
HE IS HERE 1 2 3
UNMOTIVATED FOR TREATMENT 1 2 3
UNREALISTIC
REGARDING GOALS 1 2 3

ADDITIONAL COMMENTS: (Write in Delusions and Hallucinations) _____

_____

PSYCHIATRICALLY HOMEBOUND:

A. Refuses to leave his home _____ _____
B. Not safe to leave his home unattended

_____
RN SIGNATURE DATE

STAFF ORIENTATION/COMPETENCY (BEHAVIORAL SERVICES)

Staff Name/Title: _____

Competency/Orientation providing by (Name/Title): _____

Covers overviews to behavioral health diagnoses commonly seen in its patient population and/ or those specified by governmental bodies or intermediaries as being eligible for the services.

All Agency personnel providing direct care services to patients receive an overview of mental illnesses, intellectual/developmental disabilities, and substance use/abuse diagnoses, based on the prevalence of such diagnoses seen in the patient population served by the organization. The training is appropriate to meet the needs of patients accepted by that agency and may include, but are not limited to:

- ☐ Common symptoms associated with these illnesses/disorders
- ☐ Identification of stigmatic beliefs about patients diagnosed with these illnesses/disorders
- ☐ Effective communication, identify/solve barriers
- ☐ Assessing and managing suicidal/homicidal threats
- ☐ Managing aggressive behavior of patients
- ☐ Extrapyramidal reactions to neuroleptic/antipsychotic medications
- ☐ Indications of alcohol and other drug withdrawal
- ☐ Recovery principles and self-management principles
- ☐ Working with caregivers, parents, family, significant others

☐ EMPLOYEE IS COMPETENT TO PERFORM BEHAVIORAL SERVICE TASKS

Comments: _____

_____

Staff Signature: _____ Date: _____

Trainer/Evaluator Signature: _____ Date: _____

WRAP Progress Note / Billing Form

NAME

MRN

Service Date: **RU:**

Staff #: **Hours*** **Mins** **# in Group:**

Co-Staff #: **Hours*** **Mins** **Total Travel Time: Hours** **Mins**

*** Service duration must include travel time, if applicable**

Services: (CHECK ONE)

☐ **300** No Show	☐ **311** Collateral	☐ **341** Indiv Therapy	☐ **561** Case Mgmt - Linkage
☐ **400** Client Cancel	☐ **313** Evaluation	☐ **351** Group Therapy	☐ **571** Case Mgmt - Plan Develpmt
☐ **700** Staff Cancel	☐ **315** Plan Develpmt	☐ **355** Group Rehab	☐ **540** Non-Billable –MH Services
☐ **371** Crisis Intervention	☐ **317** Rehab	☐ **357** Group Collateral	☐ **560** Non-Billable - CM Services
	☐ **331** Assessment	☐ **541** Case Mgmt - Placement	☐ **580** Non-Billable - Lock-outs

Location of Services: (CHECK ONE)

☐ **1** Office	☐ **5** School	☐ **11** Faith-based	☐ **15** Licensed Care Fac. (Adult)	☐ **19** Residential Tx Center (Child)
☐ **2** Field	☐ **8** Correctional Facility	☐ **12** Healthcare	☐ **16** Mobile Service	
☐ **3** Phone	☐ **9** Inpatient	☐ **13** Age-Specific Center	☐ **17** Non-Traditional Location	☐ **20** Telehealth
☐ **4** Home	☐ **10** Homeless/Shelter	☐ **14** Client's Job-site	☐ **18** Other	☐ **21** Unknown

Service Strategies: (CHECK UP TO THREE, IF APPLICABLE)

☐ **50** Peer/Family Services	☐ **53** Supportive Education	☐ **56** With Social Services	☐ **59** With Develpmt Disabled
☐ **51** Psycho-Education	☐ **54** With Law Enforcement	☐ **57** With Substance Abuse	☐ **60** Ethnic-specific Services
☐ **52** Family Support	☐ **55** With Health Care	☐ **58** With Aging Providers	☐ **61** Age-specific Services
			☐ **99** Unknown

☐ Interpreter Name of Interpreter:

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery, or unplanned events.

1. Description of Current Situation: (E.G. REASON FOR CONTACT; CONSUMER'S CONCERN(S); STATUS UPDATE SINCE LAST CONTACT; CLINICAL/BEHAVIORAL ACUITY; CURRENT STRESSORS; NEEDS)

2. Focus of Activity: INTERVENTION (WHAT DID YOU DO?), RESPONSE TO INTERVENTION.

3. Plan: (E.G. COORDINATION OF CARE, REFERRALS, FOLLOW-UP) *INCLUDE* **Person's Planned Action and Staff's Planned Action, as appropriate.**

Signature/License/Job Title

Documentation Date

Computer Entry Clerk Initials

Co-Signature/License (if applicable)

Date