

ASSESSMENTS

NOTE: The most up to date Assessments are present in the Electronic Health Record.
This section should contain any paper past assessments for the current program.

INITIAL SCREENING - EHR

2014

- WHEN:** Initial client contact when services are requested (phone or walk-in contact).
- NOTE:** Initial Screening ESU is only to be used by the Emergency Screening Unit (ESU). All other programs are to use the Initial Screening form.
- ON WHOM:** Should be completed on all un-“opened” clients screened for services: when there is a significant issue, when the client is not likely to be opened to the program, or when the client is referred to another agency.
Not required if Behavioral Health Assessment is started/completed on first contact.
- COMPLETED BY:** Clinical staff participating in the client contact. May not be completed by clerical staff.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.

- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

**County of San Diego Mental Health Services
INITIAL SCREENING**

***Client Name:** _____

***Case #:** _____

***Initial Screening Date:** _____

***Program Name:** _____

*Type of Contact: Telephone Face-to-Face

Informant Name: _____

Relation to Client (*Select from Relationship Table located in the Instruction Sheet*): _____

*Is the client under 18? Yes No Client's Age Today: _____ Date of Birth: _____

PARENTAL INFORMATION:

Parent Name: _____

Relationship (*Select from Relationship Table located in the Instruction Sheet*): _____

Address: _____ Phone: _____

City/State/Zip: _____

Employment Phone: _____

Other Information: *For additional responsible parent/guardian(s), enter "See Contacts Field Below". Enter any other information that might be helpful in this field.*

LEGAL INFORMATION

Legal Consent: (*Select from Legal Status Table located in the Anasazi User Manual*) _____

If other: _____

Responsible Person: _____

Relationship (*Select from Relationship Table located in the Anasazi User Manual*) _____

Address _____ Phone: _____

City/State/Zip: _____

Employment Phone: _____

Other Information *Enter other information as needed. For AB2726 clients, enter the party who has educational signing rights. For example: "John Smith has Educational Rights".*

CLIENT INFORMATION:

Client's Physical Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Whom can we call back? _____

PRESENTING PROBLEM: *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for*

Client Name:

Case #:

Initial Screening Date:

Program Name:

services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behavior, including experiences of stigma and prejudice, if any.

*Urgency Level: [] Routine [] Emergency [] Urgent [] Unspecified/Unknown

[] Initiate Second Effort Assigned Staff: _____

Date Second Effort Initiated: _____

Comments for Second Effort: _____

* Client Requests/Needs: Check all that apply:

[] Psychiatric Assessment [] Psychotherapy [] Mental Health Assessment [] Other

Is client currently taking medications: [] Yes [] No

Table with 12 columns: Med, Start Date, Is Date Estimated Y or N, Dosage/Frequency, Amt. Prescribed, Target Sxs, Taken as Prescribed? Y, N or Unk, Prescribing Physician Name, **, Refills, Stop Date, Reason for Stopping

**Physician Type: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP

History of Treatment: [] Outpatient [] Inpatient [] Psychiatric Medications

POTENTIAL FOR HARM/RISK ASSESSMENT

*Current Suicidal Ideation? [] No [] Yes [] Unknown/Refused

Specify plan (vague, passive, imminent):

Client Name:

Case #:

Initial Screening Date:

Program Name:

Access to Means? No Yes Unknown/Refused

Describe: _____

*Previous Attempts? No Yes Unknown/Refused

Describe: _____

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

No Yes Unknown/Refused

Explain: _____

*Current Homicidal Ideation? No Yes Unknown/Refused

Specify plan (vague, intent, with/without means):

Identified Victim(s)? No Yes Tarasoff Warning Indicated? No Yes

Reported To: _____ Date: _____

Victim(s) name and contact information {Tarasoff Warning Details):

Acts of Property Damage? Yes No Most Recent Date: _____

Gravely Disabled? Yes No

*Current Domestic Violence: No Yes

Describe situation:

Child/Adult Protective Services Notification Indicated? No Yes

Reported to: _____ Date: _____

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

*Substance Use? No Yes Client declined to report

Client Name:

Case #:

Initial Screening Date:

Program Name:

If Yes, specify substances used:

| Name of Drug | Priority | Method of Administration | Age 1 st used | Freq- uency of Use | Days of use in last 30 days | Date of last use | Amount of last use | Amount used on a typical Day | Largest Amount Used in One Day |
|--------------|----------|--------------------------|--------------------------|--------------------|-----------------------------|------------------|--------------------|------------------------------|--------------------------------|
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Urine Drug Screen: Positive Negative Pending Refused N/A

Breathalyzer: Positive Negative Pending Refused N/A

Comments Regarding Factors Increasing Risk:

Justice System Involvement? Yes No Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:

Insurance:

No Yes MediCal _____ Medicare _____

Other Insurance: _____

OUTCOME/DISPOSITION

*Referred to: (Select from Referred To list in Instruction Sheet): _____

If Other, Specify: _____

Referrals

Name _____

Address _____

City/State/ZIP _____

Phone _____

Person to Contact _____

Directions or Other Instructions _____

Client Name:

Case #:

Initial Screening Date:

Program Name:

Describe Outcome, Including Plan:

Signature of Staff Completing Screening:

_____ **Date** _____ **Time** _____

Signature

Printed Name _____ **Anasazi ID number** _____

**San Diego County Mental Health Services
INITIAL SCREENING
Instructions**

Anasazi Tab 1:

TYPE OF CONTACT: This is a required field. Check box: “Telephone” “Face-to-Face”.

PROGRAM: Enter your full program name in the space provided.

INFORMANT NAME: Enter the name of the person providing the information for the assessment.

RELATION TO CLIENT: Using the table below, enter the information on the form in the space provided.

| ID | DESCRIPTION | ID | DESCRIPTION | ID | DESCRIPTION |
|--------------------|-------------------------|-------------------|--------------------------------|-------------------|----------------------------|
| Aunt Bio | Aunt – Biological | Fath InLaw | Father – In-Law | Niece NBio | Niece – Non-biological |
| Aunt NoBio | Aunt – Non-biological | Gdaug Bio | Granddaughter – Biological | Other | Other |
| Bro Adop | Brother – Adopted | GDaug NBio | Granddaughter – Non-biological | Signif Oth | Significant Other |
| Bro Bio | Brother – Biological | GrFa Bio | Grandfather – Biological | Sig Supp | Significant Support Person |
| Bro Foster | Brother – Foster | GrFa NBio | Grandfather – Non-biological | Sis Adopt | Sister – Adopted |
| Bro InLaw | Brother – In-Law | GrMo Bio | Grandmother – Biological | Sis Bio | Sister – Biological |
| Bro Step | Brother – Step | GrMo NBio | Grandmother – Non-biological | Sis Foster | Sister – Foster |
| Cous Bio | Cousin – Biological | GrSon Bio | Grandson – Biological | Sis In Law | Sister – In-Law |
| Cous NBio | Cousin – Non-biological | GrSon NBio | Grandson – Non-biological | Sis Step | Sister – Step |
| Daug Adopt | Daughter – Adopted | Husband | Husband | Son Adopt | Son – Adopted |
| Daug Bio | Daughter – Biological | Mother Ado | Mother – Adopted | Son Bio | Son – Biological |
| Daug Foster | Daughter – Foster | Mother Bio | Mother – Biological | Son Foster | Son – Foster |
| Daug InLaw | Daughter – In-Law | Mother Fos | Mother – Foster | Son In Law | Son – In-Law |
| Daug Step | Daughter – Step | Mo In Law | Mother – In-Law | Son Step | Son – Step |
| Dom Partner | Domestic Partner | Mo Step | Mother – Step | Uncle Bio | Uncle - Biological |
| Fath Adop | Father – Adopted | Neph Bio | Nephew – Biological | Uncl NBio | Uncle – Non-biological |
| Fath Bio | Father – Biological | Neph NBio | Nephew – Non-biological | Wife | Wife |
| Fath Fost | Father – Foster | Niece Bio | Niece – Biological | | |

IS CLIENT UNDER 18? This field is required. Check box “Yes” or “No”.

PARENTAL INFORMATION: Enter parent name, relationship (select from relationship table above) address, home phone, employment phone, and any other information that might be helpful.

LEGAL INFORMATION:

Legal Consent: Select from the LEGAL STATUS table located in the Anasazi user manual. If status is different from the table, explain.

Responsible Person: Enter the name of the responsible person.

Relationship to the client: Enter the relationship to the client (select from relationship table located in the Anasazi user manual).

Enter address, home phone, employment phone and any other information that might be helpful.

CLIENT INFORMATION: Enter client's physical address, home phone and work phone.

WHOM CAN WE CALL BACK?: Enter the appropriate information in space provided.

PRESENTING PROBLEM: This is a Required Field. Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behavior, including experiences of stigma and prejudice, if any.

URGENCY LEVEL: This is a required field. Indicate the appropriate urgency level by selecting the appropriate check box: "Routine" "Emergency" "Urgent" "Unspecified/Unknown".

INITIATE SECOND EFFORT: Check if second effort is initiated. Document assigned staff.

DATE SECOND EFFORT WAS INITIATED: Document any comments of second effort in space provided.

CLIENT REQUESTS/NEEDS: Check all that apply.

| Description | ID |
|--------------------------|----|
| Psychiatric Assessment | P |
| Psychotherapy | T |
| Mental Health Assessment | M |
| Other | O |

CURRENT MEDICATIONS: Indicate if client is currently taking medications by selecting the appropriate check-boxes "Yes" or "No". If client is taking psychotropic medications enter in medication table provided in the form.

HISTORY OF TREATMENT: Check box: "Outpatient" "Inpatient" or "Psychiatric Medications" by selecting the appropriate check-boxes. Provide a narrative description in the space provided.

Anasazi Tab 2

POTENTIAL FOR HARM/RISK:

Current suicidal ideation: Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to specify plan "Vague" "Passive" "Imminent".

Access to Means: Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to describe any information necessary.

Previous Attempts: This is a Required Field. Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to describe any information necessary.

Does client agree not to hurt self or to seek help prior to acting on suicidal impulse: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to explain any information necessary.

Current homicidal ideation: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Intent” “With/without means”.

Identified Victim: Check box “No” or “Yes”. If yes, answer “Tarasoff Warning Indicated” check box “No” or “Yes”. Answer reported to in text box and date.

Victim(s) name and contact information (Tarasoff Warning Details): Enter in text box.

Acts of property damage: Check box “No” or “Yes” If yes, enter most recent date. Use the text box to explain any information necessary.

Gravely Disabled: Check box “No” or “Yes”. Use the text box to explain any information necessary.

Current Domestic Violence: This is a Required Field. Check box “No” or “Yes”. Use the text box to describe situation.

SUBSTANCE USE: This is a Required Field. Check box: “No” “Yes” “Client Declined to Report”. Enter substances used in table provided.

Child/Adult Protective Services Notification Indicated: Check box “No” or “Yes”.

Use text box to indicate “reported to” and “date”.

Specify Domestic Violence Plan: (include Child/Adult Protective Services information) Enter information in text box.

Urine Drug Screen: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Breathalyzer: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Comments Regarding Factors Increasing Risk: Text box is provided to enter any information necessary.

Justice System Involvement: Check box “Yes” “No” or “Unknown” If yes, describe recent arrests, probation, sex offender information, et cetera in text box provided.

Anasazi Tab 3

INSURANCE: Check box: “No” or “Yes” If yes, select “Medical” “Medicare” or “Other Insurance” and provide policy information.

OUTCOME/DISPOSITION: List the referrals made and document the outcome (including plan) in the spaces provided.

Referred to: This is a Required Field. Select from Table below.

| | | |
|--|--|---|
| Referred To: 1-ACT Program 2-ACL,211,or Other Community Support 3-CAPS 4-Case Management Program 5-Clubhouse | 6-FFS Hospital 7-FFS Provider 8-Mental Health Res Treatment Facility 9-OP Clinic 10-PEI Program 11-Primary Care Provider/FQHC | 12-SDCPH 13-Substance Abuse Treatment – OP 14-Substance Abuse Tx – Residential 15-TBS 16-Other 18-None |
|--|--|---|

Referrals: List address, phone number, person to contact, directions and other instructions.

Describe Outcome, Including Plan: Describe the outcome including plan in space provided.

SIGNATURE OF STAFF COMPLETING SCREENING: Enter the name, credential, date and Anasazi ID number for the Staff completing the screening.

**County of San Diego Mental Health Services
INITIAL SCREENING-ESU**

*Client Name: _____ *Case Number: _____

*Assessment Date: _____ *Program Name: _____

*Type of Contact: Telephone Face-to-Face

Informant Name: _____

Relation to Client (*Select from Relationship Table located in the Instruction Sheet*): _____

*Is the client under 18? Yes No

PARENTAL INFORMATION:

Parent Name: _____

Relationship (*Select from Relationship Table located in the Instruction Sheet*): _____

Address: _____ Phone: _____

City/State/Zip: _____

Employment Phone _____

Other Information: *For additional responsible parent/guardian(s), enter "See Contacts Field Below". Enter any other information that might be helpful in this field.*

Significant Support Persons *Include Name, Relationship and Phone:*

LEGAL INFORMATION

Legal Consent: (*Select from Legal Status Table located in the Anasazi User Manual*) _____

If other: _____

Responsible Person: _____

Relationship (*Select from Relationship Table located in the Anasazi User Manual*) _____

Address _____ Phone: _____

City/State/Zip: _____

Employment Phone: _____

Other Information *Enter other information as needed. For AB2726 clients, enter the party who has educational signing rights. For example: "John Smith has Educational Rights".*

CLIENT INFORMATION:

Client's Physical Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

School Attending: _____ Current Grade: _____

Client Name:

Case #

Date of Initial Screening:

Program Name:

Whom can we call back? _____

***PRESENTING PROBLEM:** Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

*Urgency Level: Routine Emergency Urgent Unspecified/Unknown

Currently on 5150? No Yes
 Danger to Self Danger to Others Gravely Disabled

Client Requests/Needs: *Check all that apply:*

Psychiatric Assessment Psychotherapy Mental Health Assessment Other

Is client currently taking medications: Yes No

| Med | Start Date | Is Date Estimated Y or N | Dosage/Frequency | Amt. Prescribed | Target Sxs | Taken as Prescribed? Y, N or Unk | Prescribing Physician Name | ** | Refills | Stop Date | Reason for Stopping |
|-----|------------|--------------------------|------------------|-----------------|------------|----------------------------------|----------------------------|----|---------|-----------|---------------------|
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****Physician Type:** 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP

Current Therapist/Clinician (Include Name and Phone Number):

History of Treatment: Outpatient Inpatient Psychiatric Medications

Client Name:

Case #

Date of Initial Screening:

Program Name:

POTENTIAL FOR HARM/RISK ASSESSMENT

*Current Suicidal Ideation? No Yes Unknown/Refused

Specify plan (vague, passive, imminent):

Access to Means? No Yes Unknown/Refused

Describe: _____

Previous Attempts? No Yes Unknown/Refused

Describe: _____

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

No Yes Unknown/Refused

Explain: _____

*Current Homicidal Ideation? No Yes Unknown/Refused

Specify plan (vague, intent, with/without means):

Identified Victim(s)? No Yes Tarasoff Warning Indicated? No Yes

Reported To: _____ Date: _____

Victim(s) name and contact information {Tarasoff Warning Details):

Acts of Property Damage? Yes No Most Recent Date: _____

Gravely Disabled? Yes No

*Current Domestic Violence: No Yes

Describe situation:

Child/Adult Protective Services Notification Indicated? No Yes

Reported to: _____ Date: _____

Client Name:

Case #

Date of Initial Screening:

Program Name:

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

***Substance Use?** **No** **Yes** **Client declined to report**

If Yes, specify substances used:

| Name of Drug | Priority | Method of Administration | Age 1 st used | Freq- uency of Use | Days of use in last 30 days | Date of last use | Amount of last use | Amount used on a typical Day | Largest Amount Used in One Day |
|--------------|----------|--------------------------|--------------------------|--------------------|-----------------------------|------------------|--------------------|------------------------------|--------------------------------|
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Urine Drug Screen: Positive Negative Pending Refused N/A

Breathalyzer: Positive Negative Pending Refused N/A

Comments Regarding Factors Increasing Risk:

Justice System Involvement? Yes No Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:

Social Security #: _____

Insurance:

No Yes MediCal _____ Medicare _____

Other Insurance: _____

Client Name:

Case #

Date of Initial Screening:

Program Name:

OUTCOME/DISPOSITION

*Referred to: *(Select from table in Instruction Sheet)* _____

Referrals

Name _____
Address _____
City/State/ZIP _____
Phone _____
Person to Contact _____
Directions or Other Instructions _____

Describe Outcome, Including Plan:

Signature of Staff Completing Screening:

_____ **Date** _____ **Time** _____

Signature

Printed Name _____ **Anasazi ID number** _____

**San Diego County Mental Health Services
INITIAL SCREENING -- ESU
Instructions**

Anasazi Tab 1:

TYPE OF CONTACT: This is a required field. Check box: “Telephone” “Face-to-Face”.

PROGRAM: Enter your full program name in the space provided.

INFORMANT NAME: Enter the name of the person providing the information for the assessment.

RELATION TO CLIENT: Using the table below, enter the information on the form in the space provided.

| ID | DESCRIPTION | ID | DESCRIPTION | ID | DESCRIPTION |
|--------------------|-------------------------|-------------------|--------------------------------|-------------------|----------------------------|
| Aunt Bio | Aunt – Biological | Fath InLaw | Father – In-Law | Niece NBio | Niece – Non-biological |
| Aunt NoBio | Aunt – Non-biological | Gdaug Bio | Granddaughter – Biological | Other | Other |
| Bro Adop | Brother – Adopted | GDaug NBio | Granddaughter – Non-biological | Signif Oth | Significant Other |
| Bro Bio | Brother – Biological | GrFa Bio | Grandfather – Biological | Sig Supp | Significant Support Person |
| Bro Foster | Brother – Foster | GrFa NBio | Grandfather – Non-biological | Sis Adopt | Sister – Adopted |
| Bro InLaw | Brother – In-Law | GrMo Bio | Grandmother – Biological | Sis Bio | Sister – Biological |
| Bro Step | Brother – Step | GrMo NBio | Grandmother – Non-biological | Sis Foster | Sister – Foster |
| Cous Bio | Cousin – Biological | GrSon Bio | Grandson – Biological | Sis In Law | Sister – In-Law |
| Cous NBio | Cousin – Non-biological | GrSon NBio | Grandson – Non-biological | Sis Step | Sister – Step |
| Daug Adopt | Daughter – Adopted | Husband | Husband | Son Adopt | Son – Adopted |
| Daug Bio | Daughter – Biological | Mother Ado | Mother – Adopted | Son Bio | Son – Biological |
| Daug Foster | Daughter – Foster | Mother Bio | Mother – Biological | Son Foster | Son – Foster |
| Daug InLaw | Daughter – In-Law | Mother Fos | Mother – Foster | Son In Law | Son – In-Law |
| Daug Step | Daughter – Step | Mo In Law | Mother – In-Law | Son Step | Son – Step |
| Dom Partner | Domestic Partner | Mo Step | Mother – Step | Uncle Bio | Uncle – Biological |
| Fath Adop | Father – Adopted | Neph Bio | Nephew – Biological | Uncl NBio | Uncle – Non-biological |
| Fath Bio | Father – Biological | Neph NBio | Nephew – Non-biological | Wife | Wife |
| Fath Fost | Father – Foster | Niece Bio | Niece – Biological | | |

IS CLIENT UNDER 18? This field is required. Check box “Yes” or “No”.

PARENTAL INFORMATION: Enter parent name, relationship (select from relationship table above) address, home phone, employment phone, and any other information that might be helpful.

SIGNIFICANT SUPPORT PERSONS: Include name, relationship and phone in space provided.

LEGAL INFORMATION:

Legal Consent: Select from the LEGAL STATUS table located in the Anasazi user manual. If status is different from the table, explain.

Responsible Person: Enter the name of the responsible person.

Relationship to the client: Enter the relationship to the client (select from relationship table located in the Anasazi user manual).

Enter address, home phone, employment phone and any other information that might be helpful.

CLIENT INFORMATION: Enter client’s physical address, home phone and work phone.

SCHOOL ATTENDING, CURRENT GRADE, WHOM CAN WE CALL BACK?: Enter the appropriate information in space provided.

PRESENTING PROBLEM: Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

URGENCY LEVEL: This is a required field. Indicate the appropriate urgency level by selecting the appropriate check box: “Routine” “Emergency” “Urgent” “Unspecified/Unknown”.

CURRENTLY ON 5150: Check box: “No” “Yes”. If Yes, specify: “Danger to Self” “Danger to Others” “Gravely Disabled”

CLIENT REQUESTS/NEEDS: Check all that apply.

| Description | ID |
|--------------------------|----|
| Psychiatric Assessment | P |
| Psychotherapy | T |
| Mental Health Assessment | M |
| Other | O |

CURRENT MEDICATIONS: Indicate if client is currently taking medications by selecting the appropriate check-boxes “Yes” or “No”. If client is taking psychotropic medications enter in medication table provided in the form.

CURRENT THERAPIST/CLINICIAN: Enter current therapist or clinician in space provided.

HISTORY OF TREATMENT: Check box: “Outpatient” “Inpatient” or “Psychiatric Medications” by selecting the appropriate check-boxes. Provide a narrative description in the space provided.

Anasazi Tab 2

POTENTIAL FOR HARM/RISK:

Current suicidal ideation: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Passive” “Imminent”.

Access to Means: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to describe any information necessary.

Previous Attempts: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to describe any information necessary.

Does client agree not to hurt self or to seek help prior to acting on suicidal impulse: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to explain any information necessary.

Current homicidal ideation: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Intent” “With/without means”.

Identified Victim: Check box “No” or “Yes”. If yes, answer “Tarasoff Warning Indicated” check box “No” or “Yes”. Answer reported to in text box and date.

Victim(s) name and contact information (Tarasoff Warning Details): Enter in text box.

Acts of property damage: Check box “No” or “Yes” If yes, enter most recent date. Use the text box to explain any information necessary.

Gravely Disabled: Check box “No” or “Yes”. Use the text box to explain any information necessary.

Current Domestic Violence: Check box “No” or “Yes”. Use the text box to describe situation.

SUBSTANCE USE: Check box: “No” “Yes” “Client Declined to Report”. Enter substances used in table provided.

Child/Adult Protective Services Notification Indicated: Check box “No” or “Yes”.

Use text box to indicate “reported to” and “date”.

Specify Domestic Violence Plan: (include Child/Adult Protective Services information) Enter information in text box.

Urine Drug Screen: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Breathalyzer: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Comments Regarding Factors Increasing Risk: Text box is provided to enter any information necessary.

Justice System Involvement: Check box “Yes” “No” or “Unknown” If yes, describe recent arrests, probation, sex offender information, et cetera in text box provided.

Anasazi Tab 3

SOCIAL SECURITY NUMBER: Enter client’s social security number.

INSURANCE: Check box: “No” or “Yes” If yes, select “Medical” Medicare” or “Other Insurance” and provide policy information.

OUTCOME/DISPOSITION: List the referrals made and document the outcome (including plan) in the spaces provided.

Referred to: This is a Required Field. Select from Table below.

| | | |
|--|--|---|
| Referred To: 1-ACT Program 2-ACL,211,or Other Community Support 3-CAPS 4-Case Management Program 5-Clubhouse | 6-FFS Hospital 7-FFS Provider 8-Mental Health Res Treatment Facility 9-OP Clinic 10-PEI Program 11-Primary Care Provider/FQHC | 12-SDCPH 13-Substance Abuse Treatment – OP 14-Substance Abuse Tx – Residential 15-TBS 16-Other 18-None |
|--|--|---|

Referrals: List address, phone number, person to contact, directions and other instructions.

Describe Outcome, Including Plan: Describe the outcome including plan in space provided.

SIGNATURE OF STAFF COMPLETING SCREENING: Enter the name, credential, date and Anasazi ID number for the Staff completing the screening.

SAFETY ALERTS - EHR

2014

- WHEN:** Safety Alerts should be used by the clinician to alert other clinicians of a possible safety risk with the client. The clinician shall exercise caution in selecting from this list as it will be visible on the client Face Sheet. The Safety Alert shall be updated when the alert no longer pertains to the client.
- ON WHOM:** ONLY a client requiring a Safety Alert.
- COMPLETED BY:** Clinical staff that have completed a thorough evaluation of the safety risks. It is expected that clinical staff consult with supervisor and/or peers before determining a system-wide Safety Alert is warranted. Reminder: the Safety Alert will be viewed by all programs working with the client.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- NOTE:** **0-5 Kids, Children, ESU, and TBS:**
The children system of care does not allow the Safety Alert be completed by an MHRS staff.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.
- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

Client Name: _____

Case #: _____

Date: _____

*Program Name: _____

San Diego County Mental Health Services
SAFETY ALERTS

*Program Name: _____

Date Completed: _____

*Allergies and Adverse Medication Reactions: No Unknown/Not Reported Yes

If Yes, specify: _____

Safety Alerts (Select from Safety Alerts table listed in the Instructions Sheet):

Signature of Staff Member Obtaining Information:

Signature

Date

Time

Printed Name

Anasazi ID number

Signature of Staff Entering Information (if different from above):

Signature

Date

Time

Printed Name

Anasazi ID number

- WHEN:** Within 30 calendar days of opening the client’s first consecutive open assignment (associated with a notification – follow the system notifications). When significant changes occur the assessment may be revised by opening a new assessment, adding the updated information, and final approving the assessment. BHA must be every 12 months at a minimum (based on the system notifications).
- ON WHOM:** All clients receiving mental health services.
- COMPLETED BY:** Staff delivering services within scope of practice. Must be signed by:
Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist,
Licensed/Registered Professional Clinical Counselor, or
Registered Nurse, Nurse Practitioner, or
Licensed Psychiatry Technician
Registered PsyD, PhD and Trainee can complete but must be co-signed by one of the above.
Co-signatures must be completed for the Behavioral Health Assessment to be final approved.
- NOTE:** The children system of care does not allow the BHA be completed by an MHRS staff.
The adult system of care does allow the BHA be completed by an MHRS staff with a co-signature.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.
- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not

BEHAVIORAL HEALTH ASSESSMENTS - EHR

2014

viewed as complete and active until the assessment is final approved (red locked).

**San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – ADULT**

*Client Name: _____ *Case #: _____

*Assessment Date: _____ * Program Name: _____

LEGAL STATUS/CASE MANAGER/PAYEE

Conservator: LPS Probate Temporary None
Case Manager: Intensive FSP Institutional SBCM
 None: _____
Payee: _____

Probation Officer: _____

***SOURCE OF INFORMATION** *Select from Source of Information Table located in the Instructions sheet*

If a source other than listed on the “Source of Information” Table, specify

Reports Reviewed: _____
Referral Source: *(Select from Table in Instruction sheet)* _____
If Other, specify: _____

PRESENTING PROBLEMS/NEEDS *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.*

PAST PSYCHIATRIC HISTORY *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.*

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

FAMILY HISTORY:

*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client: _____

Have any relatives ever been impacted by the following. Expand below if applicable:

Select from Relatives table listed in the Instructions Sheet

Suicidal thoughts, attempts: _____

Violence: _____

Domestic Violence: _____

Substance abuse or addiction: _____

Other addictions: _____

Gang Involvement: _____

Emotional/mental health issues: _____

Physical Health Issues: _____

Intellectual developmental disorder: _____

Developmental delays: _____

Arrests: _____

Abuse: _____

Abuse reported: N/A No Yes Refuse/Cannot Assess

Include relevant family information impacting the client: _____

Family Strengths: _____

EDUCATION

Area(s) of Concern: Academic Employment
 No issue reported Other: _____

Last Grade Completed: _____

Failed the following grade(s): _____

Client has an active 504 Plan: No Yes Refuse/Cannot Assess

Client has an active IEP: No Yes Refuse/Cannot Assess

Special Education: No Yes Refuse/Cannot Assess

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Is Client receiving mental health services through a school district?

No Yes Refuse/Cannot Assess

Describe: _____

Educational Strengths: _____

EMPLOYMENT: Does not apply

History of volunteer/community service: No Yes Refuse/Cannot Assess

History of work experience: No Yes Refuse/Cannot Assess

Current work experience: No Yes Refuse/Cannot Assess

Last date worked: _____

Areas of Concerns: Skills Readiness Barriers Training Job retention
 No issue reported/NA Other

Describe: _____

Employment Strengths: _____

SOCIAL CONCERNS:

Peer/Social Support No Yes Refuse/Cannot Assess

Substance use by peers No Yes Refuse/Cannot Assess

Gang affiliations No Yes Refuse/Cannot Assess

Family/community support system No Yes Refuse/Cannot Assess

Religious/spirituality No Yes Refuse/Cannot Assess

Justice system No Yes Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

MILITARY HISTORY:

Branch: _____ Date of Service: _____

Discharge Status: _____

Impact of Service/combat history: _____

CULTURAL INFORMATION: *Considerations could include language of client/family, religious/spiritual beliefs, socio-economic background, ethnicity, race, immigration history, age and subculture. Describe distinct cultural and linguistic needs and strengths that may impact treatment.*

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Experience of stigma, prejudice, or barriers to accessing services:

No Yes Refuse/Cannot Assess

Describe:

SEXUAL ORIENTATION/GENDER IDENTITY

Select One: Heterosexual Lesbian Gay Male Bisexual

Transgender

Questioning Intersex Other Decline to State Deferred

Clinical Considerations: _____

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE

History of self-injury (cutting, burning) No Yes Refuse/Cannot Assess

History of suicide attempt/s No Yes Refuse/Cannot Assess

History of violence toward another No Yes Refuse/Cannot Assess

History of significant property destruction No Yes Refuse/Cannot Assess

History of domestic violence No Yes Refuse/Cannot Assess

History of abuse

Abuse Reported N/A No Yes Refuse/Cannot Assess

Experience of traumatic event/s No Yes Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

SUBSTANCE USE INFORMATION:

Have you ever used tobacco/nicotine products? No Yes Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products: _____

Smoker Status: Current every day smoker Current some days smoker

Smoker, current status unknown Former smoker

In the past 30 days, what tobacco product did you use most frequently? (*Select from table in the Instruction Sheet*) _____

What age did you stop using tobacco/nicotine products? _____

Has the client been informed of the risks? (smoking is a serious health risk that leads to cancer, cardiovascular disease and possibility of premature death) No Yes Refuse/Cannot Assess

Have Smoking Cessation Resources been offered? No Yes Refuse/Cannot Assess

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____
History of Substance Use? No Yes Refuse/Cannot Assess

(if yes, specify substances used)

| Name of Drug | Priority | Method of Administration | Age 1 st used | Freq- uency of Use | Days of use in last 30 days | Date of last use | Amount of last use | Amount used on a typical Day | Largest Amount Used in One Day |
|--------------|----------|--------------------------|--------------------------|--------------------|-----------------------------|------------------|--------------------|------------------------------|--------------------------------|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

History of substance use treatment:

Does client have a co-occurring disorder (COD): No Yes Refuse/Cannot Assess

Quadrant:

- Q. I: Low / Low Q. II: High / Low
 Q. III: Low / High Q. IV: High / High

Stages of Change: Substance Abuse Recovery

- Pre-Contemplation Contemplation
 Preparation/Determination Action
 Maintenance Not applicable

Gambling:

- Have you ever felt the need to bet more and more money? No Yes
Have you ever had to lie to people important to you about how much you gambled?
 No Yes

If Yes: _____

HIGH RISK ASSESSMENT TAB

ASSESSMENT OF IMMEDIATE RISK FACTORS: Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required to prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program No Yes Refuse/Cannot Assess
due to suicidal or homicidal crisis (hospital, IMD, START,

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Current Violent Impulses and/or Homicidal ideation No Yes Refuse/Cannot Assess
Toward a reasonably identified victim?

Tarasoff Warning Indicated? No Yes Refuse/Cannot Assess

If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To: _____ Date: _____

CURRENT DOMESTIC VIOLENCE? No Yes Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory.

Describe Situation:

Child/Adult Protective Service Notification Indicated? No Yes Refuse/Cannot Assess

Reported To: _____ Date: _____

Signature of Clinician Requiring Co-signature:

Signature

Date

Printed Name

Anasazi ID number

Signature of Clinician Completing/Accepting the Assessment:

Signature

Date

Printed Name

Anasazi ID number

MEDICAL TAB

***ALLERGIES AND ADVERSE MEDICATION REACTIONS:**

No Yes Unknown/Not Reported

If Yes, Specify: (Share this allergy information with your medical staff.):

(Share this allergy information with your medical staff.)

Medication are recorded in the Doctors Home Page (DHP)

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Does client have a Primary Care Physician? No Yes Unknown

If No, has client been advised to seek primary care? No Yes

Primary Care Physician: _____

Phone Number: _____

Seen within the last: 6 months 12 months Other: _____

Hospital of choice (physical health): _____

Have you ever been hospitalized for any major illness? No Yes Refuse/Cannot Assess

Have you ever had an operation? No Yes Refuse/Cannot Assess

Have you had any complications from a childhood disease? No Yes Refuse/Cannot Assess

Has sleep been a problem? No Yes Refuse/Cannot Assess

Has there been a change in appetite? No Yes Refuse/Cannot Assess

A YES or REFUSE/CANNOT ASSESS response to any of the above requires detailed documentation:

Been seen for the following (provide dates of last exam):

Dental exam: _____

Hearing exam: _____

Vision exam: _____

Physical Health issues: None at this time Yes

If Yes, Specify: _____

Is condition followed by a Primary Care Physician? No Yes N/A

Physical health problems affecting mental health functioning: _____

Head injuries: No Yes

If Yes, Specify: _____

Medical and/or adaptive devices: _____

Significant Developmental Information (when applicable): _____

Healing and Health: _____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

FUNCTIONAL ASSESSMENT:

Personal care skills:

Activities daily living:

Community living skills:

Social skill:

Community educational/work activities:

Somatic safety:

- Careless smoking AWOL Assault Fire setting
 Inappropriate sexual behavior

Basic self-care:

- Incontinence Other _____

Housing at risk:

- No Yes

Recent Deaths:

Death Anniversaries:

Decision Maker:

Name: _____ Relationship: _____

Family level of involvement:

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____
 Very High High Medium Low

Primary caregiver: _____

Caregiver resources known of/used:

Caregiver burden level: Mild Moderate Severe

ILLNESS MANAGEMENT:

Access to treatment (transportation): Yes No

Knowledge of mental health status: Yes No

Engagement in treatment: Yes No

Knowledge of illness: Yes No

RECOMMENDATIONS:

Services:

- | | |
|---|---|
| <input type="checkbox"/> Acute Inpatient | <input type="checkbox"/> Partial Hospital Day Treatment |
| <input type="checkbox"/> Individual/Group Therapy | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Psycho-social/Educational Activities | <input type="checkbox"/> Other _____ |

Living Situation:

- | | |
|---|--|
| <input type="checkbox"/> Independent Living | <input type="checkbox"/> Assisted Living |
| <input type="checkbox"/> Residential | <input type="checkbox"/> SNF |
| <input type="checkbox"/> Other _____ | |

MENTAL STATUS EXAM

Unable to assess at this time.

Level of Consciousness

- Alert Lethargic Stuporous

Orientation

- Person Place Day Month Year Current Situation
 All Normal None

Appearance

- | | | | |
|--|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Good Hygiene | <input type="checkbox"/> Poor Hygiene | <input type="checkbox"/> Malodorous | <input type="checkbox"/> Disheveled |
| <input type="checkbox"/> Reddened Eyes | <input type="checkbox"/> Normal Weight | <input type="checkbox"/> Overweight | <input type="checkbox"/> Underweight |

Speech

- Normal Slurred Loud Soft Pressured

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Slow Mute

Thought Process

Coherent Tangential Circumstantial Incoherent Loose Association

Behavior

Cooperative Evasive Uncooperative Threatening Agitated Combative

Affect

Appropriate Restricted Blunted Flat Labile Other

Intellect

Average Below Average Above Average Poor Vocabulary

Poor Abstraction Paucity of Knowledge Unable to Rate

Mood

Euthymic Elevated Euphoric Irritable Depressed Anxious

Memory

Normal Poor Recent Poor Remote Inability to Concentrate

Confabulation Amnesia

Motor

Age Appropriate/Normal Slowed/Decreased Psychomotor Retardation

Hyperactive Agitated Tremors Tics Repetitive Motions

Judgment

Age Appropriate/Normal Poor Unrealistic

Fair Limited Unable to Rate

Insight

Age Appropriate/Normal Poor Fair Limited Adequate Marginal

Command Hallucinations

No Yes, specify: _____

Auditory Hallucinations

No Yes, specify: _____

Visual Hallucinations

No Yes, specify: _____

Tactile Hallucinations

No Yes, specify: _____

Olfactory Hallucinations

No Yes, specify: _____

Delusions

No Yes, specify: _____

Other observations/comments when applicable:

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

CASE MANAGEMENT (not applicable to all programs)

STRENGTHS/SUPPORT SYSTEMS:

Strengths Model is protected by Copyright (Charles A. Rapp, Ph.D. at the University of Kansas.) Used by San Diego County Mental Health Services with permission.

Daily Living Situation

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Financial/Insurance

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Vocational/Educational

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Resources – Social and Personal *(What have I used in the past?)*

Social Supports

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Health

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Leisure/Recreational

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Medical Necessity Met: No Yes

When "No," note date NOA-A issued [Medi-Cal clients only]: _____

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? Yes Date: _____

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

- Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.
- Guide to Medi-Cal Mental Health Services was explained and offered on:** _____
- Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:** _____
- Provider List explained and offered on:** _____
- Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:** _____
- Language/Interpretation services availability reviewed and offered when applicable on:** _____
- Advanced Directive brochure was offered on:** _____

Signature of Clinician Requiring Co-signature:

Signature

Date

Printed Name

Anasazi ID number:

***Signature of Clinician Completing/Accepting the Assessment:**

Signature

Date

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____
Printed Name _____ Anasazi ID number: _____

Signature of Staff Entering Information (if different from above):

Signature

Date

Printed Name

Anasazi ID number

**San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - ADULT
Instructions**

CLIENT NAME: Required Field

CASE #- Required Field.

ASSESSMENT DATE: Required Field

PROGRAM NAME- Required Field.

LEGAL STATUS/CASE MANAGER/PAYEE: Make the appropriate selections for type of conservatorship and case management by marking the corresponding check boxes for these items. Enter payee and probation officer information, if applicable, in the spaces provided.

SOURCE OF INFORMATION- Required Field. Select from the Source of information Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

| ID | Description | ID | Description |
|-------------|-----------------------|--------------------------|--------------------------|
| AB2726 Asr | AB2726 Assessor | Other | Other |
| ADS Prov | ADS Recovery Provider | Parent LG | Parent/Legal Guardian |
| Client | Client | Prev Asst | Previous Assessment |
| Case Mnager | Case Manager | Probation/Parole Officer | Probation/Parole Officer |
| Conservatr | Conservator | Soc Worker | Social Worker |
| Family | Family | Teacher | Teacher/School |
| Fos Parent | Foster Parent | Therapist | Therapist |
| MD | MD | | |

REPORTS REVIEWED: Enter any reports used as part of the assessment.

REFERRAL SOURCE: Select from the Referral Source Table Below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

| ID | Description | ID | Description |
|----|------------------------------------|----|---------------------------------------|
| 1 | ACL | 12 | Partners Program |
| 2 | CAPS | 13 | Primary Care Provider/FQHC |
| 3 | CWS | 14 | Probation |
| 4 | Case Management Program | 15 | SARB |
| 5 | Crisis Action and Connection (CAC) | 16 | School |
| 6 | ESU | 17 | Self/Family |
| 7 | FFS Hospital | 18 | Substance Abuse Treatment OP/TRC |
| 8 | FFS Provider | 19 | Substance Abuse Treatment Residential |
| 9 | Group Home/Residential Tx Facility | 20 | TBS |
| 10 | OP Clinic/School Based | 21 | Other |
| 11 | PEI Program | | |

PRESENTING PROBLEMS/NEEDS: Write in the area provided, using the help text as a guide.

PAST PSYCHIATRIC HISTORY: **Required field.** Write in the area provided, using the help text as a guide.

FAMILY HISTORY:

LIVING ARRANGEMENT: A Required Field.

Select from the Living Arrangement Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

| |
|---------------------------|
| Living Arrangement |
|---------------------------|

| | | |
|---|--|--|
| A-House or Apartment B-House or Apt with Support C-House or Apt with Daily Supervision Independent Living Facility D-Other Supported Housing Program E-Board & Care – Adult F-Residential Tx/Crisis Ctr – Adult | G-Substance Abuse Residential Rehab Ctr H-Homeless/In Shelter I-MH Rehab Ctr (Adult Locked) J-SNF/ICF/IMD K-Inpatient Psych Hospital L-State Hospital M-Correctional Facility | O-Other R-Foster Home-Child S-Group Home-Child (Level 1-12) T-Residential Tx Ctr-Child (Level 13-14) U-Unknown V-Comm Tx Facility (Child Locked) W- Children’s Shelter |
|---|--|--|

Those living in the home with client: List the names and relationship to client, and other pertinent information, in the space provided.

Have any relatives ever been impacted by the following: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

| ID | DESCRIPTION | ID | DESCRIPTION | ID | DESCRIPTION |
|--------------------|-------------------------|-------------------|--------------------------------|-------------------|----------------------------|
| Aunt Bio | Aunt – Biological | Fath InLaw | Father – In-Law | Niece Bio | Niece – Biological |
| Aunt NoBio | Aunt – Non-biological | Fath Step | Father-Step | Niece NBio | Niece – Non-biological |
| Bro Adop | Brother – Adopted | Gdaug Bio | Granddaughter – Biological | Other | Other |
| Bro Bio | Brother – Biological | GDaug NBio | Granddaughter – Non-biological | Sis Adop | Sister-Adopted |
| Bro Foster | Brother – Foster | GrFa Bio | Grandfather – Biological | Sis Bio | Sister-Biological |
| Bro InLaw | Brother – In-Law | GrFa NBio | Grandfather – Non-biological | Sis Foster | Sister – Foster |
| Bro Step | Brother – Step | GrMo Bio | Grandmother – Biological | Sis InLaw | Sister – In-Law |
| Cous Bio | Cousin – Biological | GrMo NBio | Grandmother – Non-biological | Sis Step | Sister – Step |
| Cous NBio | Cousin – Non-biological | GrSon Bio | Grandson – Biological | Son Adopt | Son-Adopted |
| Daug Adopt | Daughter – Adopted | GrSon NBio | Grandson – Non-biological | Son Bio | Son – Biological |
| Daug Bio | Daughter – Biological | Husband | Husband | Son Foster | Son – Foster |
| Daug Foster | Daughter – Foster | Mother Ado | Mother – Adopted | Son in Law | Son – In-Law |
| Daug InLaw | Daughter – In-Law | Mother Bio | Mother – Biological | Son Step | Son – Step |
| Daug Step | Daughter – Step | Mother Fos | Mother – Foster | Signif Oth | Significant Other |
| Dom Partner | Domestic Partner | Mo In Law | Mother – In-Law | Sig Supp | Significant Support Person |
| Fath Adop | Father – Adopted | Mo Step | Mother – Step | Uncle Bio | Uncle - Biological |
| Fath Bio | Father – Biological | Neph Bio | Nephew – Biological | Uncl NBio | Uncle – Non-biological |
| Fath Fost | Father – Foster | Neph NBio | Nephew – Non-biological | Wife | Wife |

Include relevant family information impacting the client: (Further explain family member’s involvement in substance use)

List all family strengths that will help client succeed.

EDUCATION: Check the appropriate boxes as indicated. Describe any items as appropriate. Describe Educational Strengths.

EMPLOYMENT: Check the appropriate boxes as indicated. Describe any items as appropriate. Enter last day worked, if appropriate. Describe Employment Strengths.

SOCIAL CONCERNS: Check all boxes as applicable. Give explanations for all “yes” answers. For Family/Community support system, include alternate relationship support, if any (such as mental health and/or substance use such as supportive/community groups, AA/NA) For Religious/Spirituality issues, document if religion/spirituality is important in a client’s life and/or a source of strength. Describe persons and practices, and how they are important. For Justice System involvement, describe what system, extent, probation/parole, time served, etc.

MILITARY HISTORY: Enter requested information in the spaces provided.

CULTURAL INFORMATION: Write in the area provided.

SEXUAL ORIENTATION/GENDER IDENTITY: Select from choices available.

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE Select appropriate check boxes. Any YES or REFUSE/CANNOT ASSESS responses require explanation.

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE: Check the boxes appropriately. A Yes or Refuse/Cannot Assess response requires detailed documentation.

SUBSTANCE USE INFORMATION: Check the boxes appropriately. If History of Substance Use marked Yes, specify substances used.

History of substance use treatment: Document as appropriate

Does client have a co-occurring disorder (COD): Check appropriate box

Quadrant: Complete if CCISC trained

Stages of Change: Substance Abuse Recovery. Complete if CCISC Trained.

Describe how substance use impacts current level of functioning if appropriate.

Recommendation for substance use treatment. Check box as appropriate. Explain if Yes is checked.

Gambling: Answer the questions as appropriate. If Yes answer, describe.

HIGH RISK ASSESSMENT

ASSESSMENT OF IMMEDIATE RISK FACTORS. Answer all questions with appropriate check box. A Yes or refuse/Cannot Assess response requires detailed documentation.

PROTECTIVE FACTORS. Document as appropriate. Use Help Text for further assistance.

SELF INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN: Document as appropriate. Use Help Text for further assistance. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

TARASOFF ASSESSMENT. Answer all questions with appropriate check box. Document details as necessary. For Yes answers.

CURRENT DOMESTIC VIOLENCE Answer all questions with appropriate check box. If Yes, documentation and child/adult protective question is mandatory. Describe the situation.

Signatures: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

MEDICAL TAB

***ALLERGIES AND ADVERSE MEDICATION REACTIONS.**

The “Allergies and adverse medication reactions” prompt **is Required**. Share any allergy information with medical staff.

The “Does client have a Primary Care Physician?” **is Required**

For rest of the Medical Tab, select appropriate check boxes. If there are any Yes answers, give explanations as appropriate.

FUNCTIONAL ASSESSMENT This is not used by all programs. Complete as appropriate.

MENTAL STATUS EXAM

Complete, selecting check boxes as appropriate. Complete the Hallucinations questions at the end of this tab, describing any Yes answers.

CASE MANAGEMENT This is not used by all programs. Complete as appropriate.

DIAGNOSTIC REVIEW TAB

DIAGNOSIS

If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL FORMULATION: Document justification and medical necessity in the space provided, using the form’s Help Text as a guide.

RECOMMENDATIONS/MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE: Provide the dates and check each item as completed.

Signatures: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

**San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – CHILDREN**

*Client Name: _____ *Case #: _____

*Assessment Date _____ * Program Name: _____

BHA CHILDREN TAB

PATHWAYS TO WELL-BEING/KTA

Client is involved with Child Welfare Services (CWS) – this section is only completed when client is involved with CWS. No Yes Refuse/Cannot Assess

May call CWS at 858-694-5191 to obtain name of current worker.

CWS PSW: _____ PSW Phone: _____ PSW email: _____

1. Legal Status for CWS client:

- VS – Voluntary Services: CWS has not filed a petition due to intent to divert from dependency by providing services; Court does not have jurisdiction
- Pre-Adjudication: CWS has filed a petition in Court (child may be with parents or may have been removed) and dependency has not yet been established
- FM – Family Maintenance: Court has jurisdiction; dependent placed at home with parent
- FR – Family Reunification: Court has jurisdiction; dependent in out of home placement
- EFC – Extended Foster Care
- PP – Permanent Plan: Court has jurisdiction – specify:
 - i. APPLA: another planned permanent living arrangement
 - ii. Legal Guardianship is pending; once finalized, dependency ends
 - iii. Adoption is pending; once finalized, dependence ends

2. CWS Child Living Arrangement:

- Parents
- Relative
- Non-Relative Extended Family Member (NREFM)
- Licensed Foster Home
- San Pasqual Academy
- Supervised Independent Living Placement (SILP)
- Foster Family Agency Home (FFA) Name: _____
- Licensed Group Home (LGH) Name: _____
- Residential Treatment Center (RTC) [LGH with a Mental Health Contract]
Name: _____
 - i. Level 12
 - ii. Level 14

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Petition True Finding based on Welfare and Institution Code, Section 300, as adjudicated by Juvenile Court (may be multiple):

- Physical Abuse
- Neglect (general or severe)
- Emotional Abuse
- Sexual Abuse
- Severe Physical Abuse of child under the age of five
- Death of another child (caused by parent)
- No parent or guardian
- Freed for adoption and adoption petition not granted
- Cruelty
- Child/client at risk due to abuse of sibling

Katie A. Class or Sub-Class status (select one based on completed Katie A. Eligibility form):

- Member of Class
- Member of Sub-Class
- Not member of Class or Sub-Class: no Child Welfare Services involvement; CWS section not applicable
- Eligibility status pending: must determine Class vs. Sub-Class status within 30 days of assignment opening

OTHER AGENCY INVOLVEMENT: Regional Center Probation

Other: _____

***SOURCE OF INFORMATION** (Select from Source of Information Table located in the Instructions sheet)

If a source other than listed on the "Source of Information" Table, specify _____

Reports Reviewed: _____

Referral Source: (Select from Referral Source Table located in the Instructions sheet)

If Other, specify: _____

PRESENTING PROBLEMS/NEEDS (Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any)

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

PAST PSYCHIATRIC HISTORY (Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods)

HISTORY OF EARLY INTERVENTIONS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Speech-Language | <input type="checkbox"/> Occupational | <input type="checkbox"/> Behavioral |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Hearing | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Parent Training | <input type="checkbox"/> Educational | <input type="checkbox"/> Developmental |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Special Education | |
| <input type="checkbox"/> Describe: _____ | | |

EDUCATION:

Area of concern: Academic Behavioral Social
 No issue reported Other: _____

Education (last grade completed): _____

Client has an active 504 Plan:: No Yes Refuse/Cannot Assess

Special Education: No Yes Refuse/Cannot Assess

Is Client receiving mental health services through a school district?:

No Yes Refuse/Cannot Assess

Describe:

Educational Strengths:

EMPLOYMENT: Does Not Apply

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

History of volunteer/community service: No Yes Refuse/Cannot Assess

History of work experience: No Yes Refuse/Cannot Assess

Current work experience: No Yes Refuse/Cannot Assess

Last date worked: No Yes Refuse/Cannot Assess

Area of Concerns: Skills Readiness Barriers Training Job retention

No issue reported/NA Other: _____

Describe: _____

Employment Strengths: _____

SOCIAL CONCERNS:

Peer/Social Support No Yes Refuse/Cannot Assess

Substance use by peers: No Yes Refuse/Cannot Assess

Gang affiliations: No Yes Refuse/Cannot Assess

Family/community support system: No Yes Refuse/Cannot Assess

Religious/spiritual issues: No Yes Refuse/Cannot Assess

Justice system involvement: No Yes Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

FAMILY HISTORY:

*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client: _____

Have any relatives ever been impacted by the following:

(Select from Relatives table listed in the Instructions Sheet) Expand below if applicable.

Suicidal thoughts, attempts: _____

Violence: _____

Substance abuse or addiction: _____

Other addictions: _____

Gang involvement: _____

Emotional/mental health issues: _____

Physical health conditions: _____

Intellectual developmental disorder:: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Developmental delays: _____

Arrests: _____

Abuse: _____

Abuse Reported: No Yes Refuse/Cannot Assess

Include relevant family information impacting the client: _____

Family strengths: _____

CULTURAL INFORMATION: (*Specific cultural explanations for symptoms of behavior. Include immigration history and acculturation*)

Experience of stigma, prejudice, or barriers to accessing services:

No Yes Refuse/Cannot Assess

Describe: _____

SEXUAL ORIENTATION/GENDER IDENTITY:

Select One: Heterosexual Lesbian Gay Male Bisexual
 Transgender Questioning Intersex Other
 Decline to State Deferred

Clinical Considerations: _____

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:

History of self-injury (cutting, burning) No Yes Refuse/Cannot Assess

History of suicide attempt/s: No Yes Refuse/Cannot Assess

History of violence toward another: No Yes Refuse/Cannot Assess

History of significant property destruction: No Yes Refuse/Cannot Assess

History of domestic violence: No Yes Refuse/Cannot Assess

History of abuse: No Yes Refuse/Cannot Assess

Abuse reported: N/A No Yes Refuse/Cannot Assess

Experience of traumatic event/s: No Yes Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above required detailed documentation:

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

SUBSTANCE USE INFORMATION:

Have you ever used tobacco/nicotine products?: No Yes Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products: _____

Smoker Status: Current every day smoker Current some day smoker
 Smoker, current status unknown Former smoker

In the past 30 days, what tobacco product did you use most frequently?

None Cigarettes Cigars Chewing Tobacco
 Pipe Snuff Other (Specify) Unknown

If Other Specify: _____

What age did you stop using tobacco/nicotine products? _____

Has the client been informed of the risks? (Smoking is a serious health risk that leads to cancer, cardiovascular disease and possibility of premature death)

No Yes Refuse/Cannot Assess

Have Smoking Cessation Resources been offered? No Yes Refuse/Cannot Assess

CRAFFT (Administer measure by providing handout or reading questions verbatim, in order and without interpretation)

| HAVE YOU EVER? | Yes | No |
|--|-----|----|
| 1. Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs? | | |
| 2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? | | |
| 3. Do you ever use alcohol or drugs while you are by yourself ALONE? | | |
| 4. Do you ever FORGET things you did while using alcohol or drugs? | | |
| 5. Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? | | |
| 6. Have you ever gotten into TROUBLE while you were using alcohol or drugs? | | |

2 or more "Yes" answers suggests dual diagnosis issues and should be explored further. **TOTAL:** _____

History of Substance Use? No Yes Refuse/Cannot Assess

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____
(if yes, specify substances used)

| Name of Drug | Priority | Method of Administration | Age 1 st used | Freq- uency of Use | Days of use in last 30 days | Date of last use | Amount of last use | Amount used on a typical Day | Largest Amount Used in One Day |
|--------------|----------|--------------------------|--------------------------|--------------------|-----------------------------|------------------|--------------------|------------------------------|--------------------------------|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

History of substance use treatment:

Does client have a co-occurring disorder (COD): No Yes Refuse/Cannot Assess

Quadrant: (CCISC – trained program/staff only)

- Q. I: Low / Low Q. II: High / Low
 Q. III: Low / High Q. IV: High / High

Stages of Change: Substance Use Recovery (CCISC – trained program/staff only)

- Pre-Contemplation Contemplation
 Preparation/Determination Action
 Maintenance

When applicable, describe how substance use impacts current level of functioning:

Recommendation for further substance use treatment: No Yes Not applicable

If Yes:

Gambling:

Have you ever felt the need to bet more and more money? No Yes Refuse/Cannot Assess

Have you ever had to lie to people important to you about how much you gambled? No Yes Refuse/Cannot Assess

If Yes: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

HIGH RISK ASSESSMENT TAB

ASSESSMENT OF IMMEDIATE RISK FACTORS: Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required to prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program No Yes Refuse/Cannot Assess
due to suicidal or homicidal crisis (hospital, IMD, START, residential treatment, etc.)

Current serious thoughts/impulses of hurting/killing self or others:
Note if access to fire arms (guns) or other lethal means: No Yes Refuse/Cannot Assess

Pre-death behaviors/committed to dying No Yes Refuse/Cannot Assess
(e.g. giving away possessions) and/or current hopelessness/sees no options

Preoccupied with incapacitating or life threatening illness No Yes Refuse/Cannot Assess
and/or chronic intractable pain and/or catastrophic social loss.

Current command hallucinations, intense paranoid delusions No Yes Refuse/Cannot Assess
and/or command override symptoms(belief that others control thoughts/actions)

Current behavioral dyscontrol with intense anger/humiliation, No Yes Refuse/Cannot Assess
recklessness, risk taking, self-injury and/or physical aggression and violence

Additional Youth Risk Factors:

Current extreme social alienation, isolation and/or victim No Yes Refuse/Cannot Assess
of bullying.

A YES or Refuse/Cannot Assess response to any other the above required detailed documentation:-

PROTECTIVE FACTORS:(strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN: (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to a higher level of care. For all

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session)

TARASOFF ASSESSMENT:

Current Violent Impulses and/or Homicidal ideation No Yes Refuse/Cannot Assess
Toward a reasonably identified victim?

Tarasoff Warning Indicated? No Yes Refuse/Cannot Assess
If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To: _____ Date: _____

CURRENT DOMESTIC VIOLENCE? No Yes Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory.

Describe Situation:

Child/Adult Protective Service Notification Indicated? No Yes Refuse/Cannot Assess

Reported To: _____ Date: _____

Signature of Clinician Requiring Co-signature:

Signature

Date

Printed Name

Anasazi ID number

Signature of Clinician Completing/Accepting the Assessment:

Signature

Date

Printed Name

Anasazi ID number

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

MENTAL STATUS EXAM TAB

Unable to assess at this time.

Level of Consciousness

Alert Lethargic Stuporous

Orientation

Person Place Day Month Year Current Situation
 All Normal None

Appearance

Good Hygiene Poor Hygiene Malodorous Disheveled
 Reddened Eyes Normal Weight Overweight Underweight

Speech

Normal Slurred Loud Soft Pressured
 Slow Mute

Thought Process

Coherent Tangential Circumstantial Incoherent Loose Association

Behavior

Cooperative Evasive Uncooperative Threatening Agitated Combative

Affect

Appropriate Restricted Blunted Flat Labile Other

Intellect

Average Below Average Above Average Poor Vocabulary
 Poor Abstraction Paucity of Knowledge Unable to Rate

Mood

Euthymic Elevated Euphoric Irritable Depressed Anxious

Memory

Normal Poor Recent Poor Remote Inability to Concentrate
 Confabulation Amnesia

Motor

Age Appropriate/Normal Slowed/Decreased Psychomotor Retardation
 Hyperactive Agitated Tremors Tics Repetitive Motions

Judgment

Age Appropriate/Normal Poor Unrealistic
 Fair Limited Unable to Rate

Insight

Age Appropriate/Normal Poor Fair Limited Adequate Marginal

Command Hallucinations

No Yes, specify: _____

Auditory Hallucinations

No Yes, specify: _____

Visual Hallucinations

No Yes, specify: _____

Tactile Hallucinations

No Yes, specify: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Olfactory Hallucinations

No Yes, specify: _____

Delusions

No Yes, specify: _____

Other observations/comments when applicable :

MEDICAL TAB

***ALLERGIES AND ADVERSE MEDICATION REACTIONS:**

No Yes Unknown/Not Reported

If Yes, Specify: **(Share this allergy information with your medical staff.):**

Does client have a Primary Care Physician? No Yes Unknown

If No, has client been advised to seek primary care? No Yes

Primary Care Physician: _____

Phone Number: _____

Seen within the last: 6 months 12 months Other: _____

Hospital of choice (physical health): _____

Been seen for the following:

Date of last dental exam: _____

Hearing seems to be normal: No Yes

Hearing has been tested: No Yes

If Yes, when? _____ Where? _____ Results: _____

Vision seems normal: No Yes

Vision has been tested: No Yes

If Yes, when? _____ Where? _____ Results: _____

Wears glasses: No Yes

Physical Health issues: None at this time Yes

If Yes, specify: _____

Is condition followed by Primary Care Physician? No Yes N/A

Physical health problems affecting mental health functioning: _____

Head injuries: No Yes

If Yes, specify: _____

Medical and/or adaptive devices: _____

Healing and Health: *(Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe):*

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

PREGNANCY/BIRTH HISTORY

During pregnancy, did the mother:

- Have any medical problems or injuries? No Yes Refuse/Cannot Assess
- Take any medications? No Yes Refuse/Cannot Assess
- Use any drugs or alcohol? No Yes Refuse/Cannot Assess
- Use tobacco? No Yes Refuse/Cannot Assess

Was the pregnancy or delivery unusual or difficult in any way? No Yes Refuse/Cannot Assess

Mother was unable to take the baby home with her when she left the hospital? No Yes Refuse/Cannot Assess

Did the child have any medical problems in infancy? No Yes Refuse/Cannot Assess

Baby's birth weight: _____ lbs. _____ oz.

A YES response to any of the above requires detailed documentation:

DEVELOPMENTAL MILESTONES:

Age at which child first:

- Crawled: _____
- Sat up alone: _____
- Walked alone: _____
- Weaned: _____
- Fed self: _____
- Bladder control: _____
- Bowel trained: _____
- First words: _____
- Spoke in complete sentences: _____

All within normal limits Unknown

Significant Developmental Information (When applicable):

MEDICAL CHECKLIST

Has the child ever had any of the following:

Client Name _____

Case Number _____

Assessment Date _____

Program Name _____

- Speech problems No Yes Refuse/Cannot Assess
- Head Banging No Yes Refuse/Cannot Assess
- Day time wetting No Yes Refuse/Cannot Assess
- Night time wetting No Yes Refuse/Cannot Assess
- Poor bowel control No Yes Refuse/Cannot Assess
- Sleep problems No Yes Refuse/Cannot Assess
- Eating problems No Yes Refuse/Cannot Assess
- More interested in things than people No Yes Refuse/Cannot Assess
- Ear infections No Yes Refuse/Cannot Assess
- High fevers No Yes Refuse/Cannot Assess
- TB No Yes Refuse/Cannot Assess
- Seizures or loss of consciousness No Yes Refuse/Cannot Assess
- Medical hospitalizations No Yes Refuse/Cannot Assess
- Operations No Yes Refuse/Cannot Assess
- Serious illness No Yes Refuse/Cannot Assess
- Child menstruating No Yes Refuse/Cannot Assess
- Pregnancies No Yes Refuse/Cannot Assess
- Venereal diseases No Yes Refuse/Cannot Assess
- Do you know child's HIV status No Yes Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

DIAGNOSTIC REVIEW TAB

DIAGNOSIS If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL FORMULATION: *(Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's strengths, ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective)*

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Medical Necessity Met: No Yes

When "No," note date NOA-A issued [Medi-Cal clients only]: _____

| |
|---|
| <p>CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? <input type="checkbox"/> Yes Date: _____</p> <p>Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:</p> <p><input type="checkbox"/> Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;</p> <p><input type="checkbox"/> They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.</p> <p><input type="checkbox"/> Guide to Medi-Cal Mental health Services was explained and offered on: _____</p> <p><input type="checkbox"/> Grievance and Appeal Process explained and Brochure with form fill & envelope offered on: _____</p> <p><input type="checkbox"/> Provider List explained and offered on: _____</p> <p><input type="checkbox"/> Mental Health Plan's Notice of Privacy Practices (NPP) was offered on: _____</p> <p><input type="checkbox"/> Language/Interpretation services availability reviewed and offered when applicable on: _____</p> <p><input type="checkbox"/> Advanced Directive brochure was offered on: _____</p> |
|---|

Signature of Clinician Requiring Co-signature:

Signature

Date

Printed Name

Anasazi ID number

Signature of Clinician Completing/Accepting the Assessment:

Signature

Date

Printed Name

Anasazi ID number

Signature of Staff Entering Information (if different from above):

Signature

Date

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Printed Name

Anasazi ID number

**San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - CHILDREN
Instructions**

CLIENT NAME: Required Field

CASE #- Required Field.

ASSESSMENT DATE – Required Field.

PROGRAM NAME- Required Field.

PATHWAYS TO WELL-BEING/KTA

Client is involved with Child Welfare Services (CWS): When this box is checked, this part of the BHA must be completed.

CWS PSW – **Required Field** : Enter PSW’s Name

PSW Phone: Enter PSW’s phone number

PSW Email: Enter PSW’s email

1. Legal Status for CWS client. Select appropriate status from choices.
PP – Permanent Plan. Select either i., ii., or iii. as appropriate.
2. CWS Child Living Arrangement. Select living status from choices.
Residential Treatment Center (RTC) [LGH with a Mental health Contract]. Enter name of facility.
indicate either Level 12 or Level 14.

Petition True Finding based on Welfare and Institution Code, Section 300, as adjudicated by Juvenile Court. Select the appropriate findings from the choices. (these may be multiple selections).

Katie A. Class or Sub-Class status. Select one from choices, based on completed Katie A. Eligibility form.

OTHER AGENCY INVOLVEMENT: Select from choices. If “Other”, document explanation.

SOURCE OF INFORMATION- Required Field. Select from the Source of information Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

| ID | Description | ID | Description |
|-----|-----------------------|------|--------------------------|
| AB | AB2726 Assessor | OTH | Other |
| ADS | ADS Recovery Provider | PAR | Parent/Legal Guardian |
| CLT | Client | PRE | Previous Assessment |
| CM | Case Manager | PRO | Probation/Parole Officer |
| CON | Conservator | SOC | Social Worker |
| FAM | Family | TEA | Teacher/School |
| FOS | Foster Parent | THER | Therapist |
| MD | MD | | |

Reports Reviewed: Enter any reports used as part of the assessment.

Referral Source: Select from the Referral Source Table Below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

| ID | Description | ID | Description |
|----|------------------------------------|----|---------------------------------------|
| 1 | ACL | 12 | Partners Program |
| 2 | CAPS | 13 | Primary Care Provider/FQHC |
| 3 | CWS | 14 | Probation |
| 4 | Case Management Program | 15 | SARB |
| 5 | Crisis Action and Connection (CAC) | 16 | School |
| 6 | ESU | 17 | Self/Family |
| 7 | FFS Hospital | 18 | Substance Abuse Treatment OP/TRC |
| 8 | FFS Provider | 19 | Substance Abuse Treatment Residential |

| | | | |
|----|------------------------------------|----|-------|
| 9 | Group Home/Residential Tx Facility | 20 | TBS |
| 10 | OP Clinic/School Based | 21 | Other |
| 11 | PEI Program | | |

PRESENTING PROBLEMS/NEEDS: Write in the area provided, using the help text as a guide.

PAST PSYCHIATRIC HISTORY: Write in the area provided, using the help text as a guide.

HISTORY OF EARLY INTERVENTION: Check the appropriate boxes as indicated. Describe results in the space provided.

EDUCATION: Check the appropriate boxes as indicated. Describe any items as appropriate. Describe Educational Strengths.

EMPLOYMENT: Check the appropriate boxes as indicated. Describe any items as appropriate. Enter last day worked, if appropriate. Describe Employment Strengths.

SOCIAL CONCERNS: Check all boxes as applicable. Give explanations for all “yes” answers. For Family/Community support system, include alternate relationship support, if any (such as mental health and/or substance use such as supportive/community groups, AA/NA) For Religious/Spirituality issues, document if religion/spirituality is important in a client’s life and/or a source of strength. Describe persons and practices, and how they are important. For Justice System involvement, describe what system, extent, probation/parole, time served, etc.

FAMILY HISTORY:

LIVING ARRANGEMENT: A Required Field.

Select from the Living Arrangement Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

| Living Arrangement | | |
|---|---|--|
| A-House or Apartment | G-Substance Abuse Residential Rehab Ctr | O-Other |
| B-House or Apt with Support | H-Homeless/In Shelter | R-Foster Home-Child |
| C-House or Apt with Daily Supervision Independent Living Facility | I-MH Rehab Ctr (Adult Locked) | S-Group Home-Child (Level 1-12) |
| D-Other Supported Housing Program | J-SNF/ICF/IMD | T-Residential Tx Ctr-Child (Level 13-14) |
| E-Board & Care – Adult | K-Inpatient Psych Hospital | U-Unknown |
| F-Residential Tx/Crisis Ctr – Adult | L-State Hospital | V-Comm Tx Facility (Child Locked) |
| | M-Correctional Facility | W- Children’s Shelter |

THOSE LIVING IN THE HOME WITH THE CLIENT: List the names and relationship to client, and other pertinent information, in the space provided

HAVE ANY RELATIVES EVER HAD ANY OF THE FOLLOWING CONDITIONS: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Expand below when applicable. Leave blank if there are none:

| ID | DESCRIPTION | ID | DESCRIPTION | ID | DESCRIPTION |
|--------------------|-------------------------|-------------------|--------------------------------|-------------------|----------------------------|
| Aunt Bio | Aunt – Biological | Fath InLaw | Father – In-Law | Niece Bio | Niece – Biological |
| Aunt NoBio | Aunt – Non-biological | Fath Step | Father-Step | Niece NBio | Niece – Non-biological |
| Bro Adop | Brother – Adopted | Gdaug Bio | Granddaughter – Biological | Other | Other |
| Bro Bio | Brother – Biological | GDaug NBio | Granddaughter – Non-biological | Sis Adop | Sister-Adopted |
| Bro Foster | Brother – Foster | GrFa Bio | Grandfather – Biological | Sis Bio | Sister-Biological |
| Bro InLaw | Brother – In-Law | GrFa NBio | Grandfather – Non-biological | Sis Foster | Sister – Foster |
| Bro Step | Brother – Step | GrMo Bio | Grandmother – Biological | Sis InLaw | Sister – In-Law |
| Cous Bio | Cousin – Biological | GrMo Nbio | Grandmother – Non-biological | Sis Step | Sister – Step |
| Cous Nbio | Cousin – Non-biological | GrSon Bio | Grandson – Biological | Son Adopt | Son-Adopted |
| Daug Adopt | Daughter – Adopted | GrSon Nbio | Grandson – Non-biological | Son Bio | Son – Biological |
| Daug Bio | Daughter – Biological | Husband | Husband | Son Foster | Son – Foster |
| Daug Foster | Daughter – Foster | Mother Ado | Mother – Adopted | Son in Law | Son – In-Law |
| Daug InLaw | Daughter – In-Law | Mother Bio | Mother – Biological | Son Step | Son – Step |
| Daug Step | Daughter – Step | Mother Fos | Mother – Foster | Signif Oth | Significant Other |
| Dom Partner | Domestic Partner | Mo In Law | Mother – In-Law | Sig Supp | Significant Support Person |
| Fath Adop | Father – Adopted | Mo Step | Mother – Step | Uncle Bio | Uncle - Biological |
| Fath Bio | Father – Biological | Neph Bio | Nephew – Biological | Uncl NBio | Uncle – Non-biological |
| Fath Fost | Father – Foster | Neph NBio | Nephew – Non-biological | Wife | Wife |

Include relevant family information impacting the client: (Further explain family member’s involvement in substance use)

Document Family Strengths.

CULTURAL INFORMATION: Write in the area provided. Refer to Help Text.

Experience of stigma, prejudice, or barriers to accessing services. Check appropriate box, describe as appropriate.

SEXUAL ORIENTATION/GENDER IDENTITY: Select from choices available. A Yes or Refuse/Cannot Assess response to any of the choices requires detailed documentation.

Document any Clinical Considerations.

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE: Check the boxes appropriately. A Yes or Refuse/Cannot Assess response requires detailed documentation.

SUBSTANCE USE INFORMATION: Check the boxes appropriately. A Yes or Refuse/Cannot Assess response requires detailed documentation.

Complete the CRAFFT.

If client has a history of substance use, specify substances used.

History of substance use treatment: Document as appropriate

Does client have a co-occurring disorder (COD): Check appropriate box

Quadrant: Complete if CCISC trained

Stages of Change: Substance Abuse Recovery. Complete if CCISC Trained.

Describe how substance use impacts current level of functioning if appropriate.

Recommendation for substance use treatment. Check box as appropriate. Explain if Yes is checked.

Gambling: Answer the questions as appropriate. If Yes answer, describe.

HIGH RISK ASSESSMENT

ASSESSMENT OF IMMEDIATE RISK FACTORS. Answer all questions with appropriate check box. A Yes or refuse/Cannot Assess response requires detailed documentation.

PROTECTIVE FACTORS. Document as appropriate. Use Help Text for further assistance.

SELF INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN: Document as appropriate. Use Help Text for further assistance. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

TARASOFF ASSESSMENT. Answer all questions with appropriate check box. Document details as necessary. For Yes answers.

CURRENT DOMESTIC VIOLENCE Answer all questions with appropriate check box. If Yes, documentation and child/adult protective question is mandatory. Describe the situation.

Signatures: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

MENTAL STATUS EXAM

Complete, selecting check boxes as appropriate. Complete the Hallucinations questions at the end of this tab, describing any Yes answers.

MEDICAL TAB

***ALLERGIES AND ADVERSE MEDICATION REACTIONS.**

The "Allergies and adverse medication reactions" prompt **is Required**. Share any allergy information with medical staff.

The "Does client have a Primary Care Physician?" **is Required**

For the rest of this section, enter the appropriate check marks and text as indicated.

For the "Healing and Health" section: Write in the area provided, using the help text as a guide.

PREGNANCY/BIRTH HISTORY Select the appropriate check boxes. A Yes response to any of the questions requires detailed documentation.

DEVELOPMENTAL MILESTONES. Select the appropriate check boxes. Document any significant information as appropriate.

MEDICAL CHECKLIST: Select the appropriate check boxes. A Yes response to any of the questions requires detailed documentation.

DIAGNOSTIC REVIEW TAB

DIAGNOSIS

If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL FORMULATION: Document justification and medical necessity in the space provided, using the form's Help Text as a guide.

RECOMMENDATIONS/MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE: Provide the dates and check each item as completed.

Signatures: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

- WHEN:** Within 30 calendar days of opening the client for TBS services. When significant changes occur the assessment may be revised by opening a new assessment, adding the updated information, and final approving the assessment. The Initial Assessment TBS does not meet the need for a Behavioral Health Assessment.
- ON WHOM:** All clients receiving TBS services.
- COMPLETED BY:** Staff delivering services within scope of practice. Must be signed by:
Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist,
Licensed/Registered Professional Clinical Counselor, or
Registered Nurse.
Registered PsyD, PhD and Trainee can complete but must be co-signed by one of the above.
Co-signatures must be completed for the Discharge Summary to be final approved.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.
- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

**San Diego County Mental Health Services
BHS TBS ASSESSMENT**

*Client Name: _____

*Case #: _____

*Assessment Date: _____

*Program Name: _____

SOURCE OF INFORMATION (Select from Source of Information Table located in the Instructions sheet):

RELATIONSHIP (Choose from Family Member List located in the instruction's sheet):

Target Behaviors: (Identify child/youth's specific behaviors/symptoms that jeopardize continued placement in a current facility or are expected to interfere when the child/youth is transitioning to a lower level of residential placement): *see table located in the instruction sheet:*

If Other, specify: _____

Describe Specific Behaviors (Identify Current frequency, severity, and duration of specific behaviors associated with Target Behaviors. Also identify the desired frequency, severity, and duration):

Identification of Current Skills (Choose from the TBS Skills Current table located in the instruction's sheet):

If Other, specify:

What interventions/consequences have been effective?

Client Name: _____

Case #: _____

Assessment Date: _____

*Program Name: _____

Medications (Active and Current Inactivations)

| Med | Start Date | Is Date Estimated Y or N | Dosage/ Frequency | Amt. Prescribed | Target Sxs | Taken as Prescribed? Y, N or Unk | Pre-scribing Physician Name | Physician Type *(see below for code) | Refills | Stop Date | Reason for Stopping |
|-----|------------|--------------------------|-------------------|-----------------|------------|----------------------------------|-----------------------------|--------------------------------------|---------|-----------|---------------------|
| | | | | | | | | | | | |
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*Physician Type: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP

Other Services or Resources Tried or Considered (Choose from the TBS Services table located in the instruction's sheet):

If Other, specify:

What were the results of these services? (Discuss duration and outcomes of previous treatment and how TBS is justified):

Desired outcome/result of TBS services:

- Prevent Higher Level of Care
- Transition to Lower of Care
- Prevent Psychiatric Hospitalization

Days and Times TBS may be requested, based on problematic behaviors:

- Monday: _____
- Tuesday: _____
- Wednesday: _____
- Thursday: _____
- Friday: _____
- Saturday: _____
- Sunday: _____

Signature of Clinician Completing/Accepting the Assessment:

Signature

Date

Printed Name

Anasazi ID number

Signature of Staff Entering Information (if different from above):

Signature

Date

Printed Name

Anasazi ID number

**San Diego County Mental Health Services
BHA TBS ASSESSMENT
Instructions**

CLIENT NAME: Required field

CASE NUMBER: Required field

ASSESSMENT DATE: Required field

PROGRAM NAME: Required field

SOURCE OF INFORMATION- Enter the name of the person providing information on the client.

| ID | Description | ID | Description |
|-------------|-----------------------|------------|-----------------------|
| AB2726 Asr | AB2726 Assessor | Other | Other |
| ADS Prov | ADS Recovery Provider | Parent LG | Parent/Legal Guardian |
| Case Mnager | Case Manager | Parole | Parole Officer |
| Client | Client | Prev Asst | Previous Assessment |
| Conservatr | Conservator | Probation | Probation Officer |
| Family | Family | Soc Worker | Social Worker |
| Fos Parent | Foster Parent | Teacher | Teacher/School |
| MD | MD | Therapist | Therapist |

RELATIONSHIP: Enter the relationship to the client of the person providing assessment information.

TARGET BEHAVIORS: Using the table below, list the target behaviors in the space provided. If “other,” then specify as indicated.

| ID | Description |
|------------|-------------------------------|
| AWOL | AWOL |
| Hygiene | Hygiene |
| Poor Bound | Poor/Inappropriate Boundaries |
| Meds non | Meds non-compliance |
| Non comp | Non-compliant Behavior |
| Opp Def Be | Oppositional Defiant Behavior |
| Other | Other |
| Phys Aggr | Physical Aggression |
| Poor Soc | Poor Social Skills |
| Prop Dest | Property Destruction |
| Sch Truan | School Truancy/Tardiness |
| Self Harm | Self-Harm Behavior |
| Sex Behav | Sexualized Behavior |
| Suicidal | Suicidal Behavior |
| Verb Aggr | Verbal Aggression |

DESCRIBE SPECIFIC BEHAVIORS: Use the space provided for narrative text.

IDENTIFICATION OF CURRENT SKILLS: Using the table below, list the client’s current skills in the space provided. If “other,” then specify as indicated.

| ID | Description |
|----------|--------------------------------------|
| Feelings | Expresses feelings asso.w prob bx |
| Predict | Predict problematic bx or situations |
| Soothe | Able to soothe self |
| Time Out | Able to take timeouts |

| | |
|------------|-----------------------------------|
| Accepts | Accepts consequences |
| Truthful | Is usually truthful |
| Other | Other |
| Remorse | Shows remorse |
| Responsibl | Takes responsibility for behavior |
| Understand | Shows remorse |

WHAT INTERVENTIONS/CONSEQUENCES HAVE BEEN EFFECTIVE: Use the space provided for narrative text.

MEDICATIONS: List medications, dosages and other pertinent information in the spaces provided.

OTHER RESOURCES TRIED OR CONSIDERED: Using the table below, list the other resources tried or considered in the space provided. If “other,” then specify as indicated. Document the results of these services where indicated.

| ID | Description |
|------------|-----------------------|
| Day Tx | Day Treatment |
| Fam Tx | Family Therapy |
| Group TX | Group Therapy |
| Hospital | Hospitalization |
| Indiv Tx | Individual Therapy |
| Meds Tx | Medication Therapy |
| Probation | Probation |
| Other | Other |
| Reg Cntr | Regional Center |
| Resl Tx | Residential Treatment |
| SES | SES |
| TBS | TBS |
| Wraparound | Wrap-around |

DESIRED OUTCOME/RESULT OF TBS SERVICES: Choose the appropriate response by marking one of the check boxes listed.

DAYS AND TIMES TBS MAY BE REQUESTED, BASED ON PROBLEMATIC BEHAVIORS: Indicate request by check box and documentation in spaces provided.

SIGNATURES: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

**County of San Diego Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – START**

Client Name: _____ **Case #:** _____

Assessment Date _____ **Program Name:** _____

BHA START TAB

LEGAL STATUS/CASE MANAGER/PAYEE

Conservator: None LPS Probate Temporary

Case Manager: None SBCM FSP Institutional
 Regional Center Other

Payee:

Probation Officer:

SOURCE OF INFORMATION: *Select from Source of Information Table located in the Instructions sheet*

If a source other than listed on the “Source of Information” Table, specify
Reports Reviewed:
Referral Source:
If Other, specify:

PRESENTING PROBLEMS/NEEDS: *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any):*

PAST PSYCHIATRIC HISTORY: *(History of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods)*

FAMILY HISTORY:

Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client:

Have any relatives ever been impacted by the following:

(Select from Relatives table listed in the Instructions Sheet): Expand below if applicable.

Suicidal thoughts, attempts:

Violence:

Domestic violence:

Substance abuse or addiction:

Other addictions:

Gang involvement:

Emotional/mental health issues:

Physical health conditions:

Intellectual developmental disorder:

Developmental delays:

Arrests:

Abuse:

Abuse reported: N/A No Yes Refuse/Cannot Assess

Include relevant family information impacting the client:

Family strengths:

EDUCATION:

Area of Concerns: Academic
 Behavioral
 Social
 No issue reported
 Other:

Last grade completed:

Failed the following grade(s):

Client has an active 504 Plan: No Yes Refuse/Cannot Assess

Client has an active IEP: No Yes Refuse/Cannot Assess

Special Education: No Yes Refuse/Cannot Assess

Is Client receiving mental health services through a school district? No Yes Refuse/Cannot Assess

Describe:

Educational Strengths:

EMPLOYMENT: Does not apply

History of volunteer/community service: No Yes Refuse/Cannot Assess

History of work experience: No Yes Refuse/Cannot Assess

Current work experience: No Yes Refuse/Cannot Assess

Last date worked:

Area of Concerns: Skills Readiness
 Barriers
 Training
 Job retention
 No issue reported/NA
 Other:

Describe:

Employment Strengths:

SOCIAL CONCERNS:

Peer/Social Support No Yes Refuse/Cannot Assess

Substance use by peers No Yes Refuse/Cannot Assess

Gang affiliations No Yes Refuse/Cannot Assess

Family/community support system No Yes Refuse/Cannot Assess

Religious/spirituality No Yes Refuse/Cannot Assess

Justice system

No Yes Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

MILITARY HISTORY:

Branch: _____ Date of Service: _____
Discharge status: _____
Impact of service/combat history: _____

CULTURAL INFORMATION: *(Considerations could include language of client/family, religious, spiritual beliefs, socio-economic background, ethnicity, race, immigration history, age, and subculture. Describe unique cultural and linguistic needs and strengths that may impact treatment).*

Experience of stigma, prejudice, barriers to accessing services

No Yes Refuse/Cannot Assess

Describe:

SEXUAL ORIENTATION/GENDER IDENTITY:

Select One: Heterosexual Lesbian Gay Male Bisexual
 Transgender Questioning Intersex Other
 Decline to State Deferred

Clinical Considerations:

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:

History of self-injury (cutting, burning) No Yes Refuse/Cannot Assess
History of suicide attempt/s: No Yes Refuse/Cannot Assess
History of violence toward another: No Yes Refuse/Cannot Assess
History of significant property destruction: No Yes Refuse/Cannot Assess
History of domestic violence: No Yes Refuse/Cannot Assess
History of abuse: No Yes Refuse/Cannot Assess
Abuse reported: N/A No Yes Refuse/Cannot Assess
Experience of traumatic event/s: No Yes Refuse/Cannot Assess

A YES or refuse/cannot assess response to any of the above requires detailed documentation:

SUBSTANCE USE INFORMATION:

Have you ever used tobacco/nicotine products? No Yes Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products: (Select value from drop down list)

Smoker Status: (Select value from drop down list)

In the past 30 days, what tobacco product did you use most frequently? (Select value from drop down list)

What age did you stop using tobacco/nicotine products?

Has the client been informed of the risks? (Smoking is a serious health risk that leads to cancer, cardiovascular disease and possibility of premature death) No Yes Refuse/Cannot Assess

Have Smoking Cessation Resources been offered? No Yes Refuse/Cannot Assess

History of Substance Use? No Yes Refuse/Cannot Assess

(if yes, specify substances used)

| Name of Drug | Priority | Method of Administration | Age 1 st used | Freq- uency of Use | Days of use in last 30 days | Date of last use | Amount of last use | Amount used on a typical Day | Largest Amount Used in One Day |
|--------------|----------|--------------------------|--------------------------|--------------------|-----------------------------|------------------|--------------------|------------------------------|--------------------------------|
| | | | | | | | | | |
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| | | | | | | | | | |

History of substance use treatment:

Does client have a co-occurring disorder (COD): No Yes Refuse/Cannot Assess

Quadrant:

- Q. I: Low / Low Q. II: High / Low
 Q. III: Low / High Q. IV: High / High

Stages of Change: Substance Abuse Recovery

- Pre-Contemplation Contemplation
 Preparation/Determination Action
 Maintenance Not applicable

When applicable, describe how substance use impacts current level of functioning:

Recommendation for further substance use treatment: No Yes Not applicable
 If Yes:

Gambling:

Have you ever felt the need to bet more and more money? No Yes Refuse/Cannot Assess
 Have you ever had to lie to people important to you about how much you gambled? No Yes Refuse/Cannot Assess
 If Yes:

HIGH RISK ASSESSMENT TAB

ASSESSMENT OF IMMEDIATE RISK FACTORS: Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program *due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.) No Yes Refuse/Cannot Assess

Current serious thoughts/impulses of hurting/killing self or others: No Yes Refuse/Cannot Assess
Note if access to fire arms (guns) or other lethal means:

Pre-death behavior/committed to dying (e.g. giving away possessions) and/or current hopelessness/sees no options No Yes Refuse/Cannot Assess

Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss No Yes Refuse/Cannot Assess

Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions) No Yes Refuse/Cannot Assess

Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence No Yes Refuse/Cannot Assess

Additional Youth Risk Factors:

Current extreme social alienation, isolation and/or victim of bullying No Yes Refuse/Cannot Assess

A YES or REFUSE/CANNOT Assess response to any of the above requires detailed documentation:

PROTECTIVE FACTORS: (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN: (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

TARASOFF ASSESSMENT:

Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim? No Yes Refuse/Cannot Assess

Tarasoff Warning Indicated? No Yes

If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To: Date:

CURRENT DOMESTIC VIOLENCE? No Yes Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:

Child/Adult Protective Services Notification Indicated? No Yes
Reported To: Date:

MEDICAL TAB

ALLERGIES AND ADVERSE MEDICATION REACTIONS: No Yes Unknown/Not Reported
If Yes, specify:

(Share this allergy information with your medical staff.)

Medications are recorded in the Doctors Home Page (DHP)

Does client have a Primary Care Physician? No Yes Unknown
If No, has client been advised to seek primary care? No Yes

Primary Care Physician:

Phone Number:

Seen within the last: 6 months 12 months Other:

Hospital of choice (physical health):

Physical Health issues: None at this time Yes
If Yes, specify:

Is condition followed by Primary Care Physician? No Yes N/A
Physical health problems affecting mental health functioning:

Head injuries: No Yes
If Yes, specify:

Medical and/or adaptive devices:

Significant Developmental Information (when applicable):

Healing and Health:

MENTAL STATUS EXAM TAB

Unable to assess at this time.

Level of Consciousness

Alert Lethargic Stuporous

Orientation

Person Place Day Month Year Current Situation
 All Normal None

Appearance

Good Hygiene Poor Hygiene Malodorous Disheveled
 Reddened Eyes Normal Weight Overweight Underweight

Speech

Normal Slurred Loud Soft Pressured Slow Mute

Thought Process

Coherent Tangential Circumstantial Incoherent Loose Association

Behavior

Cooperative Evasive Uncooperative Threatening Agitated Combative

Affect

- Appropriate Restricted Blunted Flat Labile Other

Intellect

- Average Below Average Above Average Poor Vocabulary
 Poor Abstraction Paucity of Knowledge Unable to Rate

Mood

- Euthymic Elevated Euphoric Irritable Depressed Anxious

Memory

- Normal Poor Recent Poor Remote Inability to Concentrate
 Confabulation Amnesia

Motor

- Age Appropriate/Normal Slowed/Decreased Psychomotor Retardation
 Hyperactive Agitated Tremors Tics Repetitive Motions

Judgment

- Age Appropriate/Normal Poor Unrealistic
 Fair Limited Unable to Rate

Insight

- Age Appropriate/Normal Poor Fair Limited Adequate Marginal

Command Hallucinations

- No Yes, specify:

Auditory Hallucinations

- No Yes, specify:

Visual Hallucinations

- No Yes, specify:

Tactile Hallucinations

- No Yes, specify:

Olfactory Hallucinations

- No Yes, specify:

Delusions

- No Yes, specify:

Other observations/comments when applicable :

CASE MANAGEMENT TAB

- Does not apply to program services

STRENGTHS/SUPPORT SYSTEMS:

Strengths Model is protected by Copyright (Charles A. Rapp, Ph.D. at the University of Kansas.) Used by San Diego County Mental Health Services with permission.

Daily Living Situation

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Financial/Insurance

Current Status (*What is going on today? What is available now?*)

Client’s Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Vocational/Educational

Current Status (*What is going on today? What is available now?*)

Client’s Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Social Supports

Current Status (*What is going on today? What is available now?*)

Client’s Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Health

Current Status (*What is going on today? What is available now?*)

Client’s Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Leisure/Recreational

Current Status (*What is going on today? What is available now?*)

Client’s Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Spiritual/Cultural

Current Status (*What is going on today? What is available now?*)

Client’s Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Client Priorities (*How does the client prioritize the areas above in importance?*)

BHA SIGNATURE PAGE TAB

Stages of Change: Mental Health Recovery

- | | |
|--|---|
| <input type="checkbox"/> Pre-Contemplation | <input type="checkbox"/> Contemplation |
| <input type="checkbox"/> Preparation/Determination | <input type="checkbox"/> Action |
| <input type="checkbox"/> Maintenance | <input type="checkbox"/> Not applicable |

CLINICAL FORMULATION: (*Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client’s **strengths**, ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective*)

MEDICAL NECESSITY MET: No Yes

When “No,” note date NOA-A issued [Medi-Cal clients only]:

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? Yes No Date:

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

- Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.
- Guide to Medi-Cal Mental Health Services was explained and offered on:
- Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:
- Provider List explained and offered on:
- Mental Health Plan’s Notice of Privacy Practices (NPP) was offered on:
- Language/Interpretation services availability reviewed and offered when applicable on:
- Advanced Directive brochure was offered on:
- Voter registration material was offered to client at intake or change of address:

SHORT TERM ACUTE RESIDENTIAL TREATMENT (START) ONLY:

- House Guidelines reviewed with client
- Personal Rights explained to client
- Adult/Older Adult Mental Health Outpatient Clinic information provided (includes Urgent Walk-In Services Schedule and Contact Information)
- Primary Care Physician Referrals:

Signature of Clinician Requiring Co-signature:

Signature

Date:

Printed Name Anasazi ID number:

*Signature of Clinician Completing/Accepting the Assessment:

Signature

Date:

Printed Name Anasazi ID number:

Signature of Staff Entering Information (if different from above):

Signature

Date:

Printed Name

Anasazi ID number:

(EMERGENCY SCREENING UNIT - ESU)

- WHEN:** At the time a client is assessed for need for hospitalization or any other crisis situation. When significant changes occur the assessment may be revised by opening a new assessment, adding the updated information, and final approving the assessment.
- ON WHOM:** Every client who receives a Crisis assessment.
- COMPLETED BY:** Staff delivering services within scope of practice. Must be signed by:
Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist,
Licensed/Registered/Waivered Professional Clinical Counselor,
Licensed Psychiatric Technician, or
Registered Nurse.
Registered PsyD, Phd and Trainee can complete but must be co-signed by one of the above.
Co-signatures must be completed for the Behavioral Health Assessment to be final approved.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.
- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

**San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – ESU**

*Client Name: _____ *Case #: _____

*Assessment Date _____ * Program Name: _____

Other Agency Involvement: CWS Regional Center Probation Other: _____

***SOURCE OF INFORMATION**

(Select from Source of Information Table located in the Instructions sheet): _____

If a source other than listed on the “Source of Information Table”, specify: _____

Reports Reviewed: _____

Referral Source: (Select from Table in Instruction sheet) _____

PRESENTING PROBLEMS/NEEDS *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.*

PAST PSYCHIATRIC HISTORY *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.*

EDUCATION

Area(s) of Concern: Academic Employment
 No issue reported Other: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Education (last Grade Completed): _____

Failed the following grade(s): _____

Client has an active 504 Plan: No Yes Refuse/Cannot Assess

Client has an active IEP: No Yes Refuse/Cannot Assess

Special Education: No Yes Refuse/Cannot Assess

Is Client receiving mental health services through a school district?

No Yes Refuse/Cannot Assess

Describe: _____

Educational Strengths: _____

SOCIAL CONCERNS:

Peer/Social Support No Yes Refuse/Cannot Assess

Substance use by peers No Yes Refuse/Cannot Assess

Gang affiliations No Yes Refuse/Cannot Assess

Family/community support system No Yes Refuse/Cannot Assess

Religious/spirituality No Yes Refuse/Cannot Assess

Justice system No Yes Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

FAMILY HISTORY:

**Living Arrangement: Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client: _____

Have any relatives ever been impacted by the following. Expand below if applicable:

Select from Relatives table listed in the Instructions Sheet

Suicidal thoughts, attempts: _____

Violence: _____

Domestic Violence: _____

Substance abuse or addiction: _____

Other addictions: _____

Gang Involvement: _____

Emotional/mental health issues: _____

Physical Health Issues: _____

Intellectual developmental disorder: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Developmental delays: _____

Arrests: _____

Abuse: _____

Abuse reported: N/A No Yes Refuse/Cannot Assess

Include relevant family information impacting the client: _____

Family Strengths: _____

CULTURAL INFORMATION: Considerations could include language of client/family, religious/spiritual beliefs, socio-economic background, ethnicity, race, immigration history, age and subculture. Describe distinct cultural and linguistic needs and strengths that may impact treatment.

Experience of stigma, prejudice, or barriers to accessing services:

No Yes Refuse/Cannot Assess

Describe: _____

SEXUAL ORIENTATION/GENDER IDENTITY

Select One: Heterosexual Lesbian Gay Male Bisexual Transgender
 Questioning Intersex Other Decline to State Deferred

Clinical Considerations:

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE

History of self-injury (cutting, burning) No Yes Refuse/Cannot Assess

History of suicide attempt/s No Yes Refuse/Cannot Assess

History of violence toward another No Yes Refuse/Cannot Assess

History of significant property destruction No Yes Refuse/Cannot Assess

History of domestic violence No Yes Refuse/Cannot Assess

History of abuse No Yes Refuse/Cannot Assess

Abuse Reported N/A No Yes Refuse/Cannot Assess

Experience of traumatic event/s No Yes Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

***SUBSTANCE USE INFORMATION:**

History of substance use? No Yes Refuse/Cannot Assess

(if yes, specify substances used)

| Name of Drug | Priority | Method of Administration | Age 1 st used | Freq- uency of Use | Days of use in last 30 days | Date of last use | Amount of last use | Amount used on a typical Day | Largest Amount Used in One Day |
|--------------|----------|--------------------------|--------------------------|--------------------|-----------------------------|------------------|--------------------|------------------------------|--------------------------------|
| | | | | | | | | | |
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| | | | | | | | | | |

History of substance use treatment:

Does client have a co-occurring disorder (COD): No Yes Refuse/Cannot Assess

When applicable, outline how substance use impacts current level of functioning:

Recommendation for further substance use treatment: No Yes Refuse/Cannot Assess

If Yes:

HIGH RISK ASSESSMENT TAB

ASSESSMENT OF IMMEDIATE RISK FACTORS: Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required to prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program No Yes Refuse/Cannot Assess
due to suicidal or homicidal crisis (hospital, IMD, START, residential treatment, etc.)

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Toward a reasonably identified victim?

Tarasoff Warning Indicated? No Yes Refuse/Cannot Assess

If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To: _____ Date: _____

CURRENT DOMESTIC VIOLENCE? No Yes Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory.

Describe Situation:

Child/Adult Protective Service Notification Indicated? No Yes Refuse/Cannot Assess

Reported To: _____ Date: _____

Signature of Clinician Requiring Co-signature:

Signature

Date

Printed Name

Anasazi ID number

Signature of Clinician Completing/Accepting the Assessment:

Signature

Date

Printed Name

Anasazi ID number

MENTAL STATUS EXAM

Unable to assess at this time.

Level of Consciousness

Alert Lethargic Stuporous

Orientation

Person Place Day Month Year Current Situation

All Normal None

Appearance

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

- Good Hygiene Poor Hygiene Malodorous Disheveled
 Reddened Eyes Normal Weight Overweight Underweight

Speech

- Normal Slurred Loud Soft Pressured
 Slow Mute

Thought Process

- Coherent Tangential Circumstantial Incoherent Loose Association

Behavior

- Cooperative Evasive Uncooperative Threatening Agitated Combative

Affect

- Appropriate Restricted Blunted Flat Labile Other

Intellect

- Average Below Average Above Average Poor Vocabulary
 Poor Abstraction Paucity of Knowledge Unable to Rate

Mood

- Euthymic Elevated Euphoric Irritable Depressed Anxious

Memory

- Normal Poor Recent Poor Remote Inability to Concentrate
 Confabulation Amnesia

Motor

- Age Appropriate/Normal Slowed/Decreased Psychomotor Retardation
 Hyperactive Agitated Tremors Tics Repetitive Motions

Judgment

- Age Appropriate/Normal Poor Unrealistic
 Fair Limited Unable to Rate

Insight

- Age Appropriate/Normal Poor Fair Limited Adequate Marginal

Command Hallucinations

- No Yes, specify: _____

Auditory Hallucinations

- No Yes, specify: _____

Visual Hallucinations

- No Yes, specify: _____

Tactile Hallucinations

- No Yes, specify: _____

Olfactory Hallucinations

- No Yes, specify: _____

Delusions

- No Yes, specify: _____

Other observations/comments when applicable:

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

MEDICAL TAB

***ALLERGIES AND ADVERSE MEDICATION REACTIONS:**

No Yes Unknown/Not Reported

If Yes, Specify: **(Share this allergy information with your medical staff.):**

Does client have a Primary Care Physician? No Yes Unknown

If No, has client been advised to seek primary care? No Yes

Primary Care Physician: _____

Phone Number: _____

Seen within the last: 6 months 12 months Other: _____

Physical Health issues: None at this time Yes

If Yes, specify: _____

Is condition followed by Primary Care Physician? No Yes N/A

Physical health problems affecting mental health functioning: _____

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc?

No Yes Refuse/Cannot Assess

If Yes, explain: _____

Head injuries: No Yes

If Yes, specify: _____

Medical and/or adaptive devices: _____

Significant Developmental Information (when applicable): _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

MEDICAL CHECKLIST

Has the child ever had any of the following:

- Speech problems No Yes Refuse/Cannot Assess
- Head Banging No Yes Refuse/Cannot Assess
- Day time wetting No Yes Refuse/Cannot Assess
- Night time wetting No Yes Refuse/Cannot Assess
- Poor bowel control No Yes Refuse/Cannot Assess
- Sleep problems No Yes Refuse/Cannot Assess
- Eating problems No Yes Refuse/Cannot Assess
- More interested in things than people No Yes Refuse/Cannot Assess
- Ear infections No Yes Refuse/Cannot Assess
- High fevers No Yes Refuse/Cannot Assess
- TB No Yes Refuse/Cannot Assess
- Seizures or loss of consciousness No Yes Refuse/Cannot Assess
- Medical hospitalizations No Yes Refuse/Cannot Assess
- Operations No Yes Refuse/Cannot Assess
- Serious illness No Yes Refuse/Cannot Assess
- Child menstruating No Yes Refuse/Cannot Assess
- Pregnancies No Yes Refuse/Cannot Assess
- Venereal diseases No Yes Refuse/Cannot Assess
- Do you know child's HIV status No Yes Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

DIAGNOSIS If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL FORMULATION: *Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective.*

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Medical Necessity Met: No Yes

When "No," note date NOA-A issued [Medi-Cal clients only]: _____

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? Yes Date: _____

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

- Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.
- Guide to Medi-Cal Mental Health Services was explained and offered on:** _____
- Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:** _____
- Provider List explained and offered on:** _____
- Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:** _____
- Language/Interpretation services availability reviewed and offered when applicable on:** _____
- Advanced Directive brochure was offered on:** _____

Signature of Clinician Requiring Co-signature:

Signature

Date

Printed Name

Anasazi ID number:

***Signature of Clinician Completing/Accepting the Assessment:**

Signature

Date

Printed Name

Anasazi ID number:

Signature of Staff Entering Information (if different from above):

Signature

Date

Printed Name

Anasazi ID number

HIGH RISK ASSESSMENT (HRA) INSTRUCTIONS

2014

- PURPOSE:** Suicide and violent assault are very serious public health concerns nationwide and in San Diego County. The HRA and the HRI (High Risk Index) are designed to identify, assess and create a maintenance plan for high risk clients.
- WHEN:** Completion of the HRA is required as part of the initial assessment process, upon discharge from acute care and thereafter anytime a client presents with risk factors.
- ON WHOM:** Any client receiving mental health services within BHS System of Care.
- COMPLETED BY:** Any direct service provider delivering services within their scope of practice. A Co-signature is required for all non-licensed, registered or waived staff, LVN's and LPT's.
- MODE OF COMPLETION:** Completed in Anasazi as part of the BHA. If completing on paper, it must be legibly handwritten or typed.
- REQUIRED ELEMENTS:** All elements must be assessed.
- NOTE:** The HRA is now incorporated in the BHA Child and the BHA Adult. The HRA is now required to be completed on all clients. The HRI is a paper form that is optional for use if desired to further assess Risk.
- The paper HRA and the HRI should be kept in the paper client chart.

HIGH RISK ASSESSMENT (HRA)

CLIENT NAME: _____ CASE NUMBER: _____

ASSESSMENT OF IMMEDIATE RISK FACTORS: Any "yes" response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program *due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.) No Yes Refuse/Cannot Assess

Current serious thoughts/impulses of hurting/killing self or others:
Note if access to fire arms (guns) or other lethal means: No Yes Refuse/Cannot Assess

Pre-death behavior/committed to dying (e.g. giving away possessions) and/or current hopelessness/sees no options No Yes Refuse/Cannot Assess

Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss No Yes Refuse/Cannot Assess

Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions) No Yes Refuse/Cannot Assess

Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence No Yes Refuse/Cannot Assess

Additional Youth Risk Factors:

Current extreme social alienation, isolation and/or victim of bullying No Yes Refuse/Cannot Assess

A YES or Refuse/Cannot Assess response to any of the above requires detailed documentation:

PROTECTIVE FACTORS: (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN: (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

HIGH RISK ASSESSMENT (HRA)

TARASOFF ASSESSMENT:

Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim?

No Yes Refuse/Cannot Assess

Tarasoff Warning Indicated?

No Yes

If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To: _____

Date: _____

CURRENT DOMESTIC VIOLENCE?

No Yes Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:

Child/Adult Protective Services Notification Indicated?

No Yes

Reported To: _____

Date: _____

Signature of Staff or Clinician Requiring Co-Signature: _____ Date: _____

Signature of Staff or Clinician Completing/Accepting Assessment: _____ Date: _____

HIGH RISK INDEX (HRI)

CLIENT NAME: CASE NUMBER:

HIGH RISK INDEX: A guide to determining persistent risk level (e.g. mild, moderate, severe) apart from immediate risk indicators. * Indicates a particularly **SEVERE RISK FACTOR**.

Demographic and historical factors:

- | | | | |
|--|-----------------------------|------------------------------|---|
| High risk demographic factors (age, gender, race, social status) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Sexual orientation or gender identity issues | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Suicide of 1 st degree relative | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Access to firearms or lethal means | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

Comments:

Trauma exposure and/or major life stress:

- | | | | |
|---|-----------------------------|------------------------------|---|
| Witness of suicide | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Military/veteran | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent (under 1 year) return from combat zone | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Stressful caretaking role | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Law enforcement (past or present employment) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent/ongoing victimization –commercial sex exploitation, sexual abuse, incest, physical abuse, domestic violence, bullying, or other assault | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent and unresolved major loss (people, employment, shelter, pets) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Catastrophic legal or financial problems - (Recent, within approx. 3 mos.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Release from criminal custody – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

Comments:

Clinical and/or social history:

- | | | | |
|--|-----------------------------|------------------------------|---|
| Discharge from 24 hour program (hospital, IMD, START, residential treatment, etc.) – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Alcohol/drug residential treatment failure – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Anniversary of important loss, Date: | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Health deterioration of self or significant others – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Gravely disabled – (Recent, within approximately 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current extreme social isolation (real or perceived) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Immigration/refugee issues | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Justice system involvement (past or present) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current gang exposure or involvement | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Homelessness or imminent risk thereof | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Previous attempts to harm self/others | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Experience in handling firearms | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Documented eating disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Sleeplessness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Psychomotor agitation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Panic attacks | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Guilt or worthlessness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Frequent and/or uncontrollable rage | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Impulse control problem | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Substance abuse relapse – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Co-occurring mental and substance abuse disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current abuse or misuse of drugs and other substances | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Significant change in mood – (Recent, within approx. 3 mos.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

Comments:

HIGH RISK INDEX (HRI)

High risk behaviors:

- | | | | |
|---|-----------------------------|------------------------------|---|
| *Anti-social behavior – (Recent, within approx. 3 mos.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Acts of property damage – (Recent, within approx. 3 mos.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Risk taking or self-destructive acts | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Documented borderline, anti-social, or other personality disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

Comments:

PROTECTIVE FACTORS

- | | | | |
|---|-----------------------------|------------------------------|---|
| Strong religious, cultural, or inherent values for prohibition on hurting self/others | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Strong social support system | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Positive planning for future | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Engages in treatment | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Valued care giving role (people or pets) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Strong attachment/responsibility to others | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

Comments:

Persistent risk level based upon comprehensive review of high risk index and protective factors:

- Low – no immediate plan required.
- Medium – consider enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. Consult, collaborate and document.
- High – consider enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. Consult, collaborate and document.

Comments:

For all unlicensed staff, documentation of a consultation is strongly suggested for Medium and High risk levels identified. For trainees specifically, review with supervisor should occur prior to end of session.

Signature of Staff or Clinician Requiring Co-Signature: _____ Date:

Signature of Staff or Clinician Completing/Accepting Assessment: _____ Date: