Behavioral Health/Crisis Services
Initial Screening

Is this a referral from Law Enforcement/Yellow Line Project? Yes☐No☐ (If yes, complete highlighted areas)

Date: _____ **Time:** _____

Referral: _____
Name Relationship Phone

Client's Name: _____ Client #:_____
First Middle Last

D.O.B. &/or Age: _____ **Client phone:** _____ **ok to ID**: Y / N

Gender Identification: _____

Race: ☐American Indian ☐Alaskan Native ☐Asian ☐Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐White ☐Unknown

Ethnicity: ☐Not of Hispanic Origin ☐Puerto Rican ☐Mexican ☐Cuban ☐Other Specific Hispanic
☐Hispanic Origin regardless of race ☐Unknown

Address: _____

County: _____/_____ **Social Security Number**: _____
Financial Residence

Case Manager: _____ **Aware of Referral**? Y / N

Insurance: _____ **Records Requested**? Y / N / NA

Veteran/active in the military? Y/N
Guardian: Y / N If yes, then→ **Name:** _____ **Phone/Fax**: _____

How to send documents for Guardian to sign? _____

Legal Status: VOLUNTARY 72 HR HOLD COMMITMENT_____

Has client requested emergency services in last 6 months i.e. 911, Law Enforcement, Emergency Department, Crisis Services? Y / N

What kind? _____

Hx of psychiatric hospitalizations? Y / N **Why?** _____

Psychiatrist: _____ **Therapist**: _____

Who will transport: _____**Arrival Time**: _____

Is this a mental health crisis? Y / N _____

If declined, why? _____

_____

COMPLETE THE REVERSE SIDE

Current Behaviors/Crisis:

_____

_____

_____

_____

_____

Check all that apply: _____

☐ Depressed Mood	☐ Sleep Disturbance	☐ Change in appetite
☐ Anxious/worried/fearful	☐ Anger	☐ Auditory Hallucinations
☐ Visual Hallucinations	☐ Delusions	☐ Mania
☐ Impulsivity	☐ Paranoia/Suspiciousness	☐ Panic
☐ Flashbacks or nightmares	☐ Racing thoughts	☐ Other:

Plan for Immediate Needs for Support until the Client receives crisis services: _____

_____

_____

_____

Do you have any children: ☐ Yes ☐ No **If yes, are your children in your custody**? ☐ Yes ☐ No

History of SI/attempts? Y / N Method: _____ **History of SIB**? Y / N **Type**: _____

Current suicidality? Y / N **Plan**? _____ **Current SIB**? Y / N **Type**: _____

Mental Illness Diagnosis: _____

Medical Issues: _____

Drinking/Drug Use in the last 24 hrs/currently under the influence? Y / N **Specify**: _____

History of Drinking/Drug Use? Y / N **Specify**: _____

In the past 12 months:	**No**	**Yes**
1. Have you ever felt you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

Legal Issues/History of Violence? Y / N **Specify**: _____

Current Aggression/ Homicidal? Y / N **Specify**: _____

Does third-party caller need crisis services? Y / N / N/A _____

Taking Meds as Directed? Y / N / NA **Meds in original bottles and/or scripts?** Y / N

Mobile:

If 15 and under, are parent/guardian agreeable to mobile crisis? Y / N

Is client agreeable to mobile crisis? Y / N

Is caller in a safe place? Y / N **Access to weapons?** Y / N

Who else is in the home, any pets? _____

Staff Signature: _____

MHP Approval/Declined: _____