PHASE ONE SCREENING &INITIAL INTAKE FORM

This screening form is for persons seeking admission for Mental Health Skill Building Services. MHSBS is a training service for individuals with significant mental illness. The service is designed to train individuals in functional skills and help develop healthy and appropriate behaviors to help promote, achieve and maintain community stability as well as independence in the most appropriate, least restrictive environment

PATIENT INFORMATION

Client's Name:	Sex: ❑ Male ❑ Female	Marital status (circle one) Single / Mar / Div / Sep / Wid	**Date of Referral**
Social Security No.:	Birth date: / /	Age:	VA Medicaid No
Street address:	City:	State: **VA** ZIP Code:	Phone No: ( )

Emergency Contact Name/Number:

Please list Current Psychiatric and Medical Conditions/Diagnosis:

Does client have or previously had Co-Occurring Substance Use/Abuse Disorder: ❑ no ❑ yes

If Yes please indicate frequency of use and diagnosis: _____

_____

Please Identify Current or Prior Mental Health Treatment Interventions:

❑ psychiatric hospitalization ❑ residential treatment ❑residential crisis stabilization ❑ PACT or ICT services
❑ TDO evaluation by a CSB/BHA due to mental health decompensation
❑ Outpatient therapy ❑ Case Management ❑ Medication Management/Psychiatrist

Please list medications prescribed in past 12 months

Identify the Client's Individualized training needs

❑ acquiring basic living skills ❑ help with community reintegration ❑ maintaining proper nutrition
❑ symptom management ❑ acquiring resources and support ❑ independent meal prep
❑ improving medication adherence ❑ improve health condition
❑ develop appropriate use of social skills ❑ money management ❑_____
❑ developing personal support system ❑_____
❑ improve personal hygiene; ❑_____

RISK ASSESSMENT

Is individual eminent risk of harm to self or others ❑ no ❑ yes.
If yes please explain to include plan for safety:

REFERRAL INFORMATION

Name :	Title	Agency:	Relationship to person referred
Phone:	Fax:	Address: ❑ Physical ❑ Email	

Will the referral source be an ongoing participant in services? ❑ Yes ❑ No
If yes what is anticipated involvement:

Release of Information provided ❑ Yes ❑ No

DISPOSITION:

revised 5.2017