PSYCHIATRIC REHABILITATION PROGRAM

PRE-SCREENING EVALUATION FORM FOR 18 AND YOUNGER

NAME: _____ MA#: _____

DSM V DIAGNOSIS – PLEASE INCLUDE THE NUMERICAL DIAGNOSIS AND ORDER OF PRIORITY

DIAGNOSIS:	**DURATION:**

	YES	NO
IF THE CLIENT IS IN SCHOOL, ARE THEY INVOLVED IN ANY AFTER SCHOOL ACTIVITIES, INCLUDING WORK, WHICH WOULD INTERFERE WITH DELIVERY OF PRP SERVICES 3 TIMES A MONTH?	☐	☐
IS THE CLIENT'S DEMOGRAPHIC INFORMATION (PHONE & ADDRESS) UP-TO-DATE IN OUR ELECTRONIC SYSTEM?	☐	☐
IS THE CLIENT WILLING TO PARTICIPATE IN GROUP SERVICES?	☐	☐

OTHER REFERRAL INFORMATION:	YES	NO
IS THE CLIENT ELIGIBLE FOR FULL FUNDING FOR DDA SERVICES?	☐	☐
HAVE FAMILY OR PEER SUPPORTS BEEN SUCCESSFUL FOR CLIENT?	☐	☐
IS THE PRIMARY REASON FOR IMPAIRMENT DUE TO THE FOLLOWING: ORGANIC PROCESS OR SYNDROME, INTELLECTUAL DISABILITY, NEURODEVELOPMENTAL OR NEUROCOGNITIVE DISORDER?	☐	☐
DOES THE CLIENT MEET CRITERIA FOR A HIGHER LEVEL OF CARE OTHER THAN PRP?	☐	☐
WILL THE CLIENT'S LEVEL OF COGNITIVE IMPAIRMENT, CURRENT MENTAL STATUS, OR DEVELOPMENTAL LEVEL IMPACT THEIR ABILITY TO BENEFIT FROM PRP?	☐	☐
IS THE CLIENT CURRENTLY IN MENTAL HEALTH OUTPATIENT TREATMENT?	☐	☐

_____

THERAPIST NAME / CREDENTIALS

1. DURATION OF ACTIVE, DOCUMENTED OUTPATIENT TREATMENT FOR (PLEASE CHECK ONE):
   - ☐ AT LEAST 1X/WEEK
   - ☐ AT LEAST 1X/2WEEKS
   - ☐ AT LEAST 1X/MONTH
   - ☐ AT LEAST 1X/3MONTHS
   - ☐ AT LEAST 1X/6 MONTHS

2. PLEASE LIST ANY OTHER TREATING PROVIDERS, INCLUDING PCP/MCO:

   _____

   NAME / CREDENTIALS / AGENCY

   _____

   NAME / CREDENTIALS / AGENCY

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3. DURATION OF ACTIVE, DOCUMENTED OUTPATIENT TREATMENT FOR (PLEASE CHECK ONE):
   - ☐ LESS THAN ONE MONTH
   - ☐ 1-3 MONTHS
   - ☐ 6 MONTHS OR MORE

4. IN THE PAST 3 MONTHS, HOW MANY ER VISITS HAS THE CLIENT HAD FOR PSYCHIATRIC CARE (PLEASE CHECK ONE)?
   - ☐ NO VISITS IN THE LAST 3 MONTHS
   - ☐ ONE VISIT IN THE LAST 3 MONTHS
   - ☐ TWO+ VISITS IN THE LAST 3 MONTHS

5. IS THE CLIENT TRANSITIONING FROM AN INPATIENT, DAY HOSPITAL, OR RESIDENTIAL TREATMENT SETTING TO A COMMUNITY SETTING?
   - ☐ YES
   - ☐ NO

6. DOES THE CLIENT HAS A TARGETED CASE MANAGEMENT REFERRAL OR AUTHORIZATION?
   - ☐ YES
   - ☐ NO

7. HAS MEDICATION BEEN CONSIDERED FOR THIS YOUTH (PLEASE SELECT ONE)?
   - ☐ NOT CONSIDERED
   - ☐ CONSIDERED AND RULED OUT
   - ☐ INITIATED AND WITHDRAWN
   - ☐ ONGOING
   - ☐ OTHER

8. THE CLIENT'S MENTAL ILLNESS IS THE CAUSE OF SERIOUS DYSFUNCTION/EMOTIONAL DISTURBANCE IN ONE OR MORE LIFE DOMAINS (HOME, SCHOOL, COMMUNITY); THE IMPAIRMENT RESULTS IN: (PLEASE CHECK ALL THAT APPLY – MUST SELECT AT LEAST 1 AND EXPLAIN):

   ☐ A CLEAR, CURRENT THREAT TO THE CLIENT'S ABILITY TO BE MAINTAINED IN THEIR CURRENT SETTING:

   _____

   _____

   ☐ AN EMERGING RISK TO THE SAFETY OF THE CLIENT OR OTHERS:

   _____

   _____

   ☐ SIGNIFICANT PSYCHOLOGICAL OR SOCIAL IMPAIRMENTS CAUSING SERIOUS PROBLEMS WITH PEER RELATIONSHIPS AND/OR FAMILY MEMBERS:

   _____

   _____

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PLEASE CHECK ALL THAT APPLY:

☐ THE CLIENT'S CONDITION REQUIRES AN INTEGRATED PROGRAM OF REHABILITATION SERVICES TO DEVELOP AND RETURN TO AGE APPROPRIATE DEVELOPMENT AND PROGRESS TOWARDS INDEPENDENCE.

☐ THE CLIENT DOES NOT REQUIRE A MORE INTENSIVE LEVEL OF CARE AND IS JUDGED TO BE IN ENOUGH BEHAVIORAL CONTROL TO BE SAFE IN THE REHABILITATION PROGRAM AND BENEFIT FROM THE REHABILITATION REQUIRED.

☐ THE CLIENT'S DISORDER CAN BE EXPECTED TO IMPROVE AND THERE IS CLINICAL EVIDENCE THAT THIS INTENSITY OF REHABILITATION IS NEEDED TO MAINTAIN THE INDIVIDUAL'S LEVEL OF FUNCTIONING.

☐ THE CLIENT, DUE TO DYSFUNCTION, IS AT RISK OF REQUIRING AN OUT OF HOME, RESIDENTIAL PLACEMENT, OR IS RETURNING FROM OUT OF HOME PLACEMENT OR RESIDENTIAL PLACEMENT.

9. HAVE FAMILY OR PEER SUPPORTS BEEN SUCCESSFUL FOR CLIENT?
   ☐ YES (IF YES, PLEASE EXPLAIN)
   ☐ NO

10. WHAT EVIDENCE EXISTS TO SHOW THAT THE CURRENT INTENSITY OF OUTPATIENT TREATMENT FOR THIS CLIENT (THERAPY) IS INSUFFICIENT TO REDUCE THE CLIENT'S SYMPTOMS AND FUNCTIONAL BEHAVIORAL IMPAIRMENTS RESULTING FROM MENTAL ILLNESS? (PLEASE EXPLAIN):

11. **EXAMPLE OF ADOLESCENT NARRATIVE:**
    CLIENT HAS DIFFICULTY INTERACTING WITH PEERS OFTEN RESULTING IN PHYSICAL ALTERCATIONS; IS ANGRY WITH THEIR PARENT AND OFTEN CALLS THEM DEROGATORY NAMES. CLIENT HAS RECEIVED ASSAULT CHARGES DUE TO ALTERCATIONS WITH PARENT. CLIENT IS ON FORMAL PROBATION DUE TO 2 MALICIOUS DESTRUCTION AND ASSAULT CHARGES; HAS A HISTORY OF ALCOHOL AND DRUG USE. PRP WOULD HELP REDUCE EMOTIONAL AND BEHAVIORAL PROBLEMS AT SCHOOL, HOME AND IN THE COMMUNITY. PRP WOULD HELP WITH SAFETY AS IT PERTAINS TO DRUG AND ALCOHOL EDUCATION. CLIENT WOULD BENEFIT FROM POSITIVE SOCIAL SKILLS TRAINING TO IMPROVE RELATIONSHIPS WITH FAMILY AND PEERS. CLIENT LACKS POSITIVE SOCIAL OUTLETS, IS IN NEED OF POSITIVE RECREATION ACTIVITIES TO AVOID FURTHER LEGAL ISSUES AND MAINTAIN THEIR CURRENTLY ENVIRONMENT.

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PLEASE INDICATE HOW PRP WILL SERVE TO ASSIST THIS YOUTH: PLEASE WRITE YOUR NARRATIVE HERE:

_____

_____

_____

12. HAS A CRISIS PLAN BEEN COMPLETED WITH FAMILY/GUARDIAN?
    - ☐ YES
    - ☐ NO

13. HAS AN INDIVIDUAL TREATMENT PLAN BEEN COMPLETED?
    - ☐ YES
    - ☐ NO

14. DISABILITY STATUS:

	YES	NO	N/A
IS THE CLIENT DEAF OR DO THEY HAVE A SERIOUS DIFFICULTY HEARING?	☐	☐	☐
IS THE CLIENT BLIND OR DO THEY HAVE SERIOUS DIFFICULTY SEEING, EVEN WHEN WEARING GLASSES?	☐	☐	☐
BECAUSE OF A PHYSICAL, MENTAL, OR EMOTIONAL CONDITION, DOES THE CLIENT HAVE SERIOUS DIFFICULTY CONCENTRATING, REMEMBERING, OR MAKING DECISIONS?	☐	☐	☐
DOES THE CLIENT HAVE SERIOUS DIFFICULTY WALKING OR CLIMBING STAIRS (AGE 5 OR OLDER)?	☐	☐	☐
DOES THE CLIENT HAVE DIFFICULTY DRESSING OR BATHING (AGE 5 OR OLDER)?	☐	☐	☐
BECAUSE OF A PHYSICAL, MENTAL OR EMOTIONAL CONDITION, DOES THE CLIENT HAVE DIFFICULTY DOING ERRANDS ALONE SUCH AS VISITING A DOCTOR'S OFFICE OR SHOPPING?	☐	☐	☐

15. EMPLOYMENT STATUS:
    - ☐ STUDENT
    - ☐ VOLUNTEER
    - ☐ EMPLOYED FULL TIME
    - ☐ EMPLOYED PART TIME
    - ☐ DISABLED

16. TOBACCO USE IN THE PAST 30 DAYS?
    - ☐ YES
    - ☐ NO

17. DOES CLIENT SMOKE CIGARETTES?
    - ☐ YES
    - ☐ NO

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18. HAS CLIENT PARTICIPATED IN A SELF-HELP GROUP IN THE LAST 30 DAYS?
    - ☐ YES (IF YES, NUMBER OF TIMES IN SELF-HELP GROUP IN THE PAST 30 DAYS _____)
    - ☐ NO

19. NUMBER OF DEPENDENT CHILDREN: _____

20. PRIMARY SOURCE OF INCOME: _____

21. CLIENT'S BASIC NEEDS ARE BEING MAINTAINED (HOUSING, UTILITIES, ETC.)
    - ☐ YES
    - ☐ NO

22. PRP WORKER SAFETY:
    - ☐ IS IT RECOMMENDED THAT CLIENT BE SEEN AT THE CLINIC INSTEAD OF HOME DUE TO SAFETY?

    IF SELECTED, EXPLAIN:

    _____
    _____
    _____

23. SUBSTANCE ABUSE INFORMATION

    IS THERE A HISTORY OF SUBSTANCE ABUSE?
    - ☐ YES
    - ☐ NO

    IS THE CLIENT INVOLVED IN SUBSTANCE ABUSE TREATMENT?
    - ☐ YES (IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION)
    - ☐ NO

    A. PRIMARY SUBSTANCE USED: _____
    - AGE OF FIRST USE: _____
    - ROUT OF ADMINISTRATION: _____
    - FREQUENCY OF USE: _____
    - DATE LAST USED: _____

    B. SECONDARY SUBSTANCE USED: _____
    - AGE OF FIRST USE: _____
    - ROUTE OF ADMINISTRATION: _____
    - FREQUENCY OF USE: _____
    - DATE LAST USED: _____