

**OPTIONAL PEI OUTCOMES WORKSHEET****First Break/TAY: Portland Identification and Early Referral (PIER)****ADMINISTRATIVE INFORMATION**

Client ID	<input type="text"/>	Client First Name	<input type="text"/>
Client Last Name	<input type="text"/>	Therapist ID/NPI #	<input type="text"/>
Provider ID	<input type="text"/>		

**END OF TREATMENT INFORMATION**

Date of Last (EBP Treatment) Session  Total Number of EBP Treatment Sessions

Completed EBP? ☐ Yes ☐ No If YES, Client's Treatment Success? ☐ Significant ☐ Partial

**If Client COMPLETED EBP, Please Check One for Disposition**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Began New EBP               | <input type="checkbox"/> Linked to MHS at Another Agency | <input type="checkbox"/> Case Closed                    |
| <input type="checkbox"/> Continued in Concurrent EBP | <input type="checkbox"/> Began Non-PEI MHS               | <input type="checkbox"/> Linked to Non-MHS in Community |

**If Client DID NOT COMPLETE EBP, Please Check One for Disposition**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> New EBP with Different Focus | <input type="checkbox"/> Deceased                    | <input type="checkbox"/> Foster Care/Residential Placement |
| <input type="checkbox"/> New EBP with Same Focus      | <input type="checkbox"/> Psychiatric Hospitalization | <input type="checkbox"/> Continued in Concurrent EBP       |
| <input type="checkbox"/> Arrested                     | <input type="checkbox"/> Moved                       | <input type="checkbox"/> Linked to Non-MHS in Community    |
| <input type="checkbox"/> Detained by DCFS             | <input type="checkbox"/> Unable to Contact           | <input type="checkbox"/> Linked to MHS at Another Agency   |
| <input type="checkbox"/> Medical Hospitalization      | <input type="checkbox"/> Withdrew                    | <input type="checkbox"/> Began Non-PEI MHS                 |

**END OF TREATMENT QUESTIONNAIRES**Scale of Prodromal Symptoms (Clients Ages 12-35) Admin. Date **Positive Symptoms (P)**

- P. 1. Unusual Thought Content/Delusional Ideas
- P. 2. Suspiciousness/Persecutory Ideas
- P. 3. Grandiosity
- P. 4. Perceptual Abnormalities/Hallucinations
- P. 5. Disorganized Communication

**P TOTAL SCORE****Disorganization Symptoms (D)**

- D. 1. Odd Behavior or Appearance
- D. 2. Bizarre Thinking
- D. 3. Trouble with Focus and Attention
- D. 4. Personal Hygiene

**D TOTAL SCORE**

If "Unable to Collect," Enter

Number from Below

**Negative Symptoms (N)**

- N. 1. Social Anhedonia
- N. 2. Avolition
- N. 3. Expression of Emotion
- N. 4. Experience of Emotions and Self
- N. 5. Ideational Richness
- N. 6. Occupational Functioning

**N TOTAL SCORE****General Symptoms (G)**

- G. 1. Sleep Disturbance
- G. 2. Dysphoric Mood
- G. 3. Motor Disturbances
- G. 4. Impaired Tolerance to Normal Stress

**G TOTAL SCORE****TOTAL OF ALL SCORES****Global Assessment of Functioning-Modified**Admin. Date **SCORE**

If "Unable to Collect," Enter

Number from Below

**Reasons for "Unable to Collect"**

- |   |   |                                       |
|---|---|---------------------------------------|
| 1. Administered Wrong Form                      | 5. Clinician not Trained in Outcome Measure | 9. Outcome Measure Unavailable        |
| 2. Administration Date Exceeds Acceptable Range | 6. Invalid Outcome Measure                  | 10. Premature Termination             |
| 3. Client Refused                               | 7. Lost Contact with Client                 | 11. Therapist did not Administer Tool |
| 4. Client Unavailable                           | 8. Not Available in Primary Language        |                                       |