Universal Assessment

Interviewed: ☐ Client and/or ☐ Other (name and relationship): _____

Was assessment conducted in language other than English? ☐ Yes ☐ No Language: _____

SPECIAL SERVICE NEEDS:

☐ Cultural Considerations, specify: _____

☐ Physically challenged (wheelchair, hearing, visual, etc.), specify:_____

☐ Access issues (transportation, hour, etc.), specify:_____

I. REASON FOR REFERRAL/CHIEF COMPLAINT

PRECIPITATING EVENT(S)/REASON FOR REFERRAL
CURRENT SYPTOMS AND BEHAVIORS (INTENSITY, DURATION, ONSET, FREQUENCY) and **IMPAIRMENTS IN LIFE FUNCTIONING** caused by the symptoms/behaviors (from perspective of client and others):

SUICIDAL THOUGHTS/ATTEMPTS: "*Columbia Suicide Severity Rating Scale Screener (LACDMH Version)"*

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.*

1. Within the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up?
   ☐ Yes ☐ No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

2. Within the past 30 days, have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

If YES to #2, ask questions 3, 4, 5 and 6
If NO to 2, go directly to question 6

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No

Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?
   ☐ Yes ☐ No

Suicidal Behavior:

6. Have you done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No

If yes, How long ago did you do any of these? _____

Additional comments regarding suicidal thoughts/attempts:

Self-Harm (without statement of suicidal intent) ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe:

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II. MENTAL HEALTH HISTORY

Outpatient and inpatient history (include dates, providers, interventions, and responses)

III. CURRENT RISK AND SAFETY CONCERNS

See Information on _____ dated: _____

Current Thoughts of Self-injurious behavior	☐ Yes ☐ No	Past Thoughts of Self-injurious behaviors	☐ Yes ☐ No
Probation/Parole Involvement	☐ Yes ☐ No	Current/History of Injuring Animals	☐ Yes ☐ No
Recent Trauma Exposure	☐ Yes ☐ No	Recent Job Loss	☐ Yes ☐ No
Victim of Violence/Abuse	☐ Yes ☐ No	DCFS Involvement	☐ Yes ☐ No
Access to Guns/Weapons	☐ Yes ☐ No	Current Thoughts of Harming Another Person	☐ Yes ☐ No
Past Thoughts of Harming Another Person	☐ Yes ☐ No	History of Homicide/Manslaughter	☐ Yes ☐ No
History of Injuring Another Person	☐ Yes ☐ No	School Issues or IEP in Place	☐ Yes ☐ No
Current Substance Use/Abuse	☐ Yes ☐ No	Past Substance Use/Abuse	☐ Yes ☐ No
Perpetrator of Violence/Abuse	☐ Yes ☐ No		

Other (specify):

For any risk/safety concerns marked, please explain. Identify if any safety measures are needed, required, or taken.

IV. RELEVANT MEDICAL CONDITIONS

Hearing Impairment ☐ Yes ☐ No Visual Impairment ☐ Yes ☐ No Motor Impairment ☐ Yes ☐ No

Other Sensory Impairment ☐ Yes ☐ No If yes, specify: _____

Allergies ☐ Yes ☐ No If yes, specify: _____

Other Medical Conditions ☐ Yes ☐ No If yes, specify: _____

Last Physical Exam Date:

For any marked yes, please specify. Other Comments Regarding Medical Conditions:

(For ages 0-5 Years old, refer to DC 0-5 Axis III Physical Health Conditions)

For ages 0-5 years old

Describe any perinatal mood and anxiety disorders, prenatal complications/concerns *(illnesses, accidents, stressors during pregnancy such as homelessness/domestic or interpersonal violence)*:

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V. DEVELOPMENTAL HISTORY

Describe developmental history, making note of developmental milestones and environmental stressors

Were any developmental milestones delayed or not met? ☐ Yes ☐ No
If yes, which: (Multi-select option)

- ☐ Motor Skills (sit, crawl, walk)
- ☐ Speech
- ☐ Eating
- ☐ Sleeping
- ☐ Toilet Training
- ☐ Coordination
- ☐ Temperament
- ☐ Separation
- ☐ Social Adjustment
- ☐ Sexual Behaviors
- ☐ Self-Care
- ☐ Child Care/School Adjustment
- ☐ Peer & Adult Relations/Friends
- ☐ Impulse Control

Development Assessment Tools & Results

Were the Ages and Stages Questionnaires completed? ☐ Yes ☐ No
If yes, enter the following Domain Scores:

Communication: _____
Gross Motor: _____
Fine Motor: _____
Problem Solving: _____
Personal-Social: _____
Comments:

Has any other developmental screening been conducted? ☐ Yes ☐ No
Comments regarding type and results:

Did Mother use alcohol, cigarettes, drugs while pregnant? ☐ Yes ☐ No
Any challenges with pregnancy? ☐ Yes ☐ No
If yes, please describe:

VI. MEDICATIONS

History of psychiatric medications: ☐ Yes ☐ No

Client is currently on psychiatric medications: ☐ Yes ☐ No If yes, How many days of medications does the client have left?
_____

Specify **all** current or past medications (include name, dosage/frequency, period taken, and if there are any side-effects/adverse reactions).

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VII. SUBSTANCE USE/ABUSE

Child/Adolescent Screening Questions

Part A

		Yes	No
1.	During the past 12 months, did you drink any alcohol (more than a few sips)? *(Do not count sips of alcohol taken during family or religious events)*	☐	☐
2.	During the past 12 months, did you smoke any marijuana or hashish?	☐	☐
3.	During the past 12 months, did you use anything else to get high?	☐	☐
4.	During the past 12 months, did you use a vaping device containing nicotine and/or flavors, or use any tobacco products?	☐	☐

If the client answered "yes" to any questions in Part A, continue with Part B.

Part B

		Yes	No
5.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using alcohol or drugs?	☐	☐
6.	Do you ever use alcohol or drugs to **RELAX,** feel better about yourself, or fit in?	☐	☐
7.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
8.	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
9.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
10.	Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?	☐	☐

Assessment/Additional Information

PAST AND PRESENT USE OF TOBACCO, ALCOHOL, CAFFEINE, CAM (COMPLEMENTARY AND ALTERNATIVE MEDICATIONS) AND OVER-THE COUNTER, AND ILLICIT DRUGS. Be sure to include route or administration, frequency (amount), withdrawals, etc. Also, include any relevant information from other sources (i.e., teachers, social workers, etc.)

Parent/caregiver comments/concerns regarding client's relationship with alcohol or drugs:
May utilize MH552 Co-Occurring Substance Use Parent/Caregiver Questionnaire

Adult Screening Questions

Does the client currently appear to be under the influence of alcohol or drugs? ☐ Yes ☐ No ☐ Unable to Assess

When was the last time the client used alcohol or drugs? _____

A. Alcohol Screening Questions *1 Drink = 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor*

1. In the past year, how often did you have a drink containing alcohol?	☐ Never (0)	☐ Monthly or less (1)	☐ 2-4 times a month (2)	☐ 3 times a week (3)	☐ 4+ times a week (4)

If "Never", proceed to Drug Screening Questions.

1a. In the past year, how many drinks containing alcohol did you have on a typical day when you are drinking?	☐ 1 or 2 (0)	☐ 3 or 4 (1)	☐ 5 or 6 (2)	☐ 7 to 9 (3)	☐ 10+ (4)
1b. In the past year, how often did you have Six or more drinks on one occasion?	☐ Never (0)	☐ Less than monthly (1)	☐ Monthly (2)	☐ Weekly (3)	☐ Daily or almost daily (4)

Alcohol Screening Score: _____

Low risk/abstain = score of 0-3
Moderate/high risk = score of 3-7 (women) and score 4-7 (men)
Severe risk (provide a brief intervention) = score of 8 or more

Was a brief intervention provided? ☐ Yes ☐ No

B. Drug Screening Questions *("Yes" to any of the questions below indicate a positive screening)*

	Ever Used?		Recently Used? (within past 6 months)	
	Yes	No	Yes	No
1. Have you used nicotine products? *(Cigarettes, Cigars, electronic cigarettes, smokeless tobacco)*	☐	☐	☐	☐
2. Do you use products containing caffeine, such as tea, coffee or high-caffeine energy drinks? *(Such as AMP, Monster, Red Bull or 5 Hour Energy)*	☐	☐	☐	☐
3. Have you used Opioids? *(Heroin, opium, fentanyl, non-prescription pain medications)*	☐	☐	☐	☐
4. Have you used prescription medications, over the counter medications, and/or non-prescription supplements in a manner other than prescribed? *(For example, to get high; such as prescription opioids)*	☐	☐	☐	☐
5. Have you used stimulants, such as cocaine or methamphetamine?	☐	☐	☐	☐
6. Have you used Marijuana? *(smoked, edibles, wax, or other)*	☐	☐	☐	☐
7. Have you used hallucinogens? *(MDMA or Ecstasy, LSD, PCP, mushrooms or Psilocin)*	☐	☐	☐	☐
8. Have you used drugs intravenously?	☐	☐	☐	☐
9. Have you used other substances of abuse?	☐	☐	☐	☐

C. Are you interested in changing your substance use pattern? ☐ Yes ☐ No ☐ N/A

Assessment/Additional Information (answer only if screening is positive)
PAST AND PRESENT USE OF TOBACCO, ALCOHOL, CAFFEINE, CAM (COMPLIMENTARY AND ALTERNATIVE MEDICATIONS) AND OVER-THE-COUNTER, AND ILLICIT DRUGS, if not determined by screener. Be sure to include route of administration, frequency (amount), withdrawals, etc.

VIII. RELEVANT PSYCHOSOCIAL INFORMATION

Describe any of the following issues that may impact treatment/linkage/referral: *education/school history, employment history, vocational information, legal/Juvenile Court history, child abuse/protective service information, dependent care issues, current and past living situations, family history/relationships, family strengths, culture, religion and/or spirituality*

Is the client homeless? (*An individual, unaccompanied youth, or family (with or without minor children in their custody) who lack a fixed, regular, and adequate nighttime residence, which includes living: In a homeless shelter / car or RV / hotel On the street In a street encampment In an institution such as a hospital, jail/prison, or juvenile detention facility and will be homeless upon release*)**:**
☐ **Yes** ☐ **No** ☐ **Unable to Assess**

If yes, when did the client become homeless (estimated date)? _____
Military Service: ☐ **Yes** ☐ **No** ☐ **Unable to Assess**

IX. OTHER AGENCY INVOLVEMENT

☐ DCFS ☐ Probation/Parole ☐ DPSS ☐ Health ☐ Outside Meds ☐ Regional Center
☐ Substance Abuse/12 Steps ☐ Consumer Run/NAMI ☐ Education/IEP
☐ Other _____

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X. MENTAL STATUS EXAM Instructions: Check all descriptions that apply

Child/Adolescent Mental Status

Apparent Age:
☐ Younger ☐ Stated age ☐ Older

Weight:
☐ Normal range ☐ Underweight ☐ Overweight

Cleanliness/Grooming/Attire:
☐ Well Groomed ☐ Clean/Normal for age
☐ Disheveled/Messy ☐ Dirty/Odorous/Neglected

Behavior:
Activity Level:
☐ Normal/Age appropriate ☐ Hyperactive
☐ Fidgety ☐ Hypoactive ☐ Lethargic
☐ Mannerisms ☐ Tics

Gross Motor:
☐ Intact ☐ Impaired

Fine Motor:
☐ Intact ☐ Impaired

Behavioral Disturbances:
☐ Aggressive ☐ Poor impulse control
☐ Passive ☐ None

Manner of Relating to Examiner – Eye Contact:
☐ Good/Age Appropriate ☐ Limited
☐ Avoided ☐ Staring

Ability to Cooperate and Engage:
☐ Cooperative ☐ Indifferent ☐ Anxious
☐ Withdrawn ☐ Seductive ☐ Oppositional
☐ Aggressive ☐ Other:_____

Relatedness to Caregiver:
☐ Appropriate ☐ Defiant/disobedient
☐ Clinging ☐ Bossy ☐ Not observed

Speech and Language
Rate:
☐ Normal ☐ Rapid ☐ Pressured ☐ Slow

Volume:
☐ Normal ☐ Loud ☐ Soft

Clarity:
☐ Clear ☐ Slurred ☐ Mumbled
☐ Stuttered ☐ Incoherent

Content:
☐ Normal/Age Appropriate ☐ Hyper-verbal
☐ Impoverished w/ little detail ☐ Mute/Non-verbal

Thought Content – Delusions
☐ Persecutory ☐ Grandiose ☐ Paranoid
☐ Religious ☐ Somatic ☐ None

Hallucinations:
☐ Auditory/Reacting to internal stimuli
☐ Visual ☐ Tactile ☐ Olfactory ☐ None

Anxiety:
☐ Fears/Phobias ☐ Obsessions
☐ Compulsions/Rituals
☐ Separation difficulties ☐ None

Thought Process:
☐ Normal/Linear ☐ Disorganized

If disorganized indicate:
☐ Circumstantial ☐ Flight of ideas
☐ Paucity of ideas ☐ Rumination ☐ Tangential
☐ Loose associations ☐ Thought blocking

Alertness/Attention and Concentration:
☐ Alert ☐ Focused ☐ Short attention span
☐ Tired/lethargic ☐ Easily distractable
☐ Other:_____

Orientation:
☐ Oriented ☐ Disoriented

If disoriented, disoriented to:
☐ Time ☐ Place ☐ Person

Memory:
Short-term:
☐ Intact ☐ Impaired ☐ N/A due to age

Long-term:
☐ Intact ☐ Impaired ☐ N/A due to age

Fund of Knowledge/Intelligence
☐ Average ☐ Above Average ☐ Below Average

Cognitive Ability/Insight
☐ Good ☐ Poor ☐ Fair ☐ N/A due to age

Mood:
☐ Euthymic/Normal ☐ Fearful/Anxious ☐ Angry
☐ Euphoric ☐ Sad/Tearful ☐ Irritable/Agitated
☐ Silly ☐ Other:_____

Affect/Expression:
☐ Normal Range ☐ Incongruent w/ mood
☐ Blunted ☐ Labile ☐ Congruent w/ mood
☐ Restricted/Constricted ☐ Flat

Examination of Risk – Suicidal
☐ Denies ☐ Admits

If suicidal, indicate:
☐ Thoughts ☐ Plan ☐ Intent ☐ Recent Attempt

Examination of Risk – Homicidal
☐ Denies ☐ Admits

If homicidal, indicate
☐ Thoughts ☐ Plan ☐ Intent ☐ Recent Attempt

Comments on Child/Adolescent Mental Status:

Age 0-5 Years Old Mental Status
Provide a description of this child based on your observations.

Appearance - Dress, grooming, unusual physical characteristics:

Behavior - Activity level, mannerisms, eye contact, manner of relating to caregiver/therapist, motor behavior, aggression, impulsivity:

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Socio-Emotional/Mood/Affect – ☐ Shy ☐ Fearful ☐ Labile ☐ Sad ☐ Blunt ☐ Irritable ☐ Aggressive ☐ Passive ☐ Depressed ☐ Anxious ☐ Slow to warm up ☐ Easy going ☐ Difficult
Ability to co-regulate and ability to self-regulate, frustration tolerance (e.g., reaction to transitions/adaptation):

Risk to Self/Others:

Thought Content – Expressing worrisome thoughts, expressing developmentally inappropriate fantasies:

Cognitive – Attention span and play are age-appropriate, problem-solving ability:

Communication/Language – Verbal/nonverbal, receptive/expressive, age-appropriate, emotional expression:

Sensorimotor – Visual, auditory, tactile, vestibular, proprioceptive, taste, textures, smells (over-reactive, under-reactive, typical), reaction to stimuli:

Gross Motor – Coordination, motor planning, postural stability:

Fine Motor – Coordination, tremors, etc.:

Muscle Tone – Low, floppy, tense:

Adaptive Functioning – Age-appropriate self-care, feeding, toileting:

Play – (e.g., parallel play, cooperative play):

Unusual Behaviors – (e.g., Repetitive behaviors, head-banging, breath-holding):

Strengths – Adaptive capacity, strengths & assets, cooperation:

Observed Caregiver - Child Interaction
Refer to the DC:0-5 Manual, Axis II Relational Context (Refer to Caregiving Dimensions and Infant/Young Child's Contributions to Relationship Tables)

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Adult Mental Status

General Description

Grooming & Hygiene:
☐ Well Groomed ☐ Average ☐ Dirty ☐ Odorous
☐ Disheveled ☐ Bizarre

Eye Contact:
☐ Normal for culture ☐ Little ☐ Avoids
☐ Erratic

Motor Activity:
☐ Calm ☐ Restless ☐ Agitated ☐ Tremors/Tics
☐ Posturing ☐ Rigid ☐ Retarded ☐ Akathisia
☐ E.P.S.

Speech:
☐ Unimpaired ☐ Soft ☐ Slowed ☐ Mute
☐ Pressured ☐ Loud ☐ Excessive
☐ Slurred ☐ Incoherent ☐ Poverty of Content

Interactional Style:
☐ Culturally congruent ☐ Cooperative
☐ Sensitive ☐ Guarded/Suspicious
☐ Overly Dramatic ☐ Negative ☐ Silly

Orientation:
☐ Oriented
☐ Disoriented to:
☐ Time ☐ Place ☐ Person ☐ Situation

Intellectual Functioning:
☐ Unimpaired ☐ Impaired

Memory:
☐ Unimpaired
☐ Impaired re: ☐ Immediate ☐ Remote
☐ Recent ☐ Amnesia

Fund of Knowledge:
☐ Average ☐ Below Average ☐ Above Average

Mood and Affect

Mood:
☐ Euthymic ☐ Dysphoric ☐ Tearful ☐ Irritable
☐ Lack of Pleasure ☐ Hopeless/Worthless
☐ Anxious ☐ Known Stressor
☐ Unknown Stressor

Affect:
☐ Appropriate ☐ Labile ☐ Expansive
☐ Constricted ☐ Blunted ☐ Flat ☐ Sad
☐ Worried

Perceptual Disturbance

☐ None Apparent

Hallucinations:
☐ Visual ☐ Olfactory ☐ Tactile
☐ Auditory: ☐ Command ☐ Persecutory
☐ Other

Self-Perceptions:
☐ Depersonalizations ☐ Ideas of Reference

Thought Process Disturbances

☐ None Apparent

Associations:
☐ Unimpaired ☐ Loose ☐ Tangential
☐ Circumstantial ☐ Confabulation
☐ Flight of Ideas ☐ Word Salad

Concentration:
☐ Intact ☐ Impaired by: ☐ Rumination
☐ Thought Blocking
☐ Clouding of Consciousness ☐ Fragmented

Abstractions:
☐ Intact ☐ Concrete

Judgments:
☐ Intact
☐ Impaired re: ☐ Minimum ☐ Moderate
☐ Severe

Insight:
☐ Adequate
☐ Impaired re: ☐ Minimum ☐ Moderate
☐ Severe

Serial 7's: ☐ Intact ☐ Poor

Thought Content Disturbance

☐ None Apparent

Delusions:
☐ Persecutory ☐ Paranoid ☐ Grandiose
☐ Somatic ☐ Religious ☐ Nihilistic
☐ Being Controlled

Ideations:
☐ Bizarre ☐ Phobic ☐ Suspicious ☐ Obsessive
☐ Blames Others ☐ Persecutory
☐ Assaultive Ideas ☐ Magical Thinking
☐ Irrational/Excessive Worry
☐ Sexual Preoccupation
☐ Excessive/Inappropriate Religiosity
☐ Excessive/Inappropriate Guilt

Behavioral Disturbances:
☐ None ☐ Aggressive ☐ Uncooperative
☐ Demanding ☐ Demeaning ☐ Belligerent
☐ Violent ☐ Destructive ☐ Self-Destructive
☐ Poor Impulse Control
☐ Excessive/Inappropriate Display of Anger
☐ Manipulative ☐ Antisocial

Suicidal:
☐ Denies ☐ Ideation Only ☐ Threatening
☐ Plan

Homicidal:
☐ Denies ☐ Ideation Only ☐ Threatening
☐ Target(s) ☐ Plan

Passive:
☐ Amotivational ☐ Apathetic ☐ Isolated
☐ Withdrawn ☐ Evasive ☐ Dependent

Other:
☐ Disorganized ☐ Bizarre
☐ Obsessive/compulsive ☐ Ritualistic
☐ Excessive/Inappropriate Crying

Comments on Adult Mental Status:

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XI. CLINICAL FORMULATION AND DIAGNOSIS

STRENGTHS *(to assist with achieving treatment goals)*

CLINICAL FORMULATION AND DIAGNOSTIC JUSTIFICATION *Summarize/conceptualize all clinical information to determine the client's diagnosis and include initial proposal(s) for treatment. Be sure to identify any impairments in life functioning due to the client's diagnosis (Medical Necessity). Formulation should include risk factors as well as any significant strengths that can assist the client with treatment.*

CLINICAL IMPAIRMENTS: ☐ **Social** ☐ **Vocational** ☐ **Educational**
(*For the impairments selected, please explain below*):

DIAGNOSTIC DESCRIPTOR:

_____
_____
_____
_____
_____
_____
_____

ICD DIAGNOSIS CODE (check at least one Primary)

☐ Primary Code _____
☐ Sec Code _____
Code _____
Code _____
Code _____
Code _____
Code _____

XII. DISPOSITION/PLAN

CARE PLAN

Problems:

Goal(s) (Focus of Treatment)

☐ Improve MOOD regulation
☐ Manage ANXIETY
☐ Manage HALLUCINATIONS
☐ Manage STRESS
☐ Manage IMPULSIVITY
☐ Decrease SUICIDAL IDEATIONS
☐ Decrease SELF HARM BEHAVIORS
☐ Improve SELF-ESTEEM
☐ Improve SLEEP
☐ Finding a PURPOSE
☐ Increase SUPPORT SYSTEM
☐ Enhance SOCIAL SKILLS
☐ Develop healthier LIFE HABITS
☐ Improve SCHOOL Performance
☐ Attend SCHOOL or EDUCATIONAL facility
☐ Obtain & or stabilize HOUSING
☐ Obtain & or keep a JOB
☐ Reduce SUBSTANCE USE
☐ Other:

Goal details:

Planned Intervention:

☐ Psychotherapy
☐ Family Therapy
☐ Group Therapy
☐ Skills Group
☐ Medication Management
☐ Linkage & Referral
☐ Teach Skills (Rehab)
☐ Peer Support
☐ Intensive Care Coordination
☐ Intensive Home Based Services
☐ Therapeutic Behavioral Services
☐ Day Treatment
☐ Other:

Intervention details:

Client and or family was involved in development of the plan: ☐ Yes

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Assessment Closure Reason:

☐ Client attended the initial appointment, but did not complete the assessment
☐ Client completed the assessment, met criteria to access SMHS, but declined treatment
☐ Client completed the assessment, and did not meet criteria to access SMHS (NOABD provided to client)
☐ Client completed the assessment, did not meet criteria to access SMHS, but will receive services (e.g., CalWorks)
☐ Client completed the assessment, met criteria to access SMHS, and will receive services

Next MHS/TCM/ICC/IHBS Appt (includes Plan Development, Psychotherapy, or Rehabilitation) _____

Was an earlier appointment offered? ☐ Yes ☐ No Date of First Offered Appointment _____

Interested in and appropriate for Initial Medication Eval? ☐ Yes ☐ No

Next Medication Support Services Appointment _____

Was an earlier Med appointment offered? ☐ Yes ☐ No Date of First Offered Med Appointment _____

SIGNATURE:

_____	_____	_____	_____
Assessor's Signature & Discipline	Date	Co-Signature & Discipline	Date

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