SFC CO-LOCATED MENTAL HEALTH TRIAGE

I. Initial Contact Data:

Date: _____ **Telephone Contact:** ☐ **In Person:** ☐

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

Children: Individual resides with ☐ Biological parent(s) ☐ Adoptive Parent ☐ Foster Parent ☐ Other _____

Household Constellation (adults/children/pets): _____

Referral Source (list contact info if available):

Describe situation resulting in triage information gathering (who present, meeting, agencies, referral packet, etc.):

II. Special Service Needs

☐ Non-English Speaking, specify language needs: _____
Were Interpretive Services provided for this interview? ☐ Yes ☐ No

☐ Cultural Considerations, specify: _____

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

☐ Access issues (transportation, hours), specify: _____

III. Reason for Referral/Chief Complaint/Presenting Situation

Why is the child being referred? (Be sure to document where this information comes from, i.e. child, caregiver, DCFS, etc)

Describe precipitating event, behaviors, and symptoms.

Impairments in Life Functioning: ☐ Individual does not appear to have significant impairments
Individual appear to have significant impairment(s) or the probability of deterioration in the following area(s):
(check all that apply and give comments below)

☐ Living Arrangements ☐ Social Support/Peer Relations ☐ Financial Status/Money Management
☐ Daily Living/Vocation/Education ☐ Physical Health ☐ Legal Status
☐ For those under the age of 21, probability of not progressing developmentally in an appropriate manner

☐ See attached DCFS Referral Form for additional information

Name: **IS#:**

Agency: **Provider #:**

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IV. Psychiatric History

How long has this presenting situation been a problem?

☐ See attached IS Screen Print
☐ See attached DCFS Referral Form
☐ See information below for contacts/services not in the IS or on the DCFS Referral Form

Current Medications including non-psychiatric (list Names and other pertinent information such as compliance with meds):
☐ See attached DCFS Referral Form

If currently on psychiatric medications, how long is the supply good for? _____

V. Current Risk and Safety Concerns

☐ See attached DCFS Referral Form

Current Thoughts of Self-Harm/Suicide	☐Yes	☐No	Current Thoughts of Harming Another Person	☐Yes	☐No
Past Thoughts of Self-Harm/Suicide	☐Yes	☐No	Past Thoughts of Harming Another Person	☐Yes	☐No
Prior Suicide Attempts	☐Yes	☐No	History of Homicide/Manslaughter	☐Yes	☐No
Probation Involvement	☐Yes	☐No	History of Injuring Another Person	☐Yes	☐No
Current/History of Injuring Animals	☐Yes	☐No	School Issues or IEP in place	☐Yes	☐No
Recent Trauma Exposure	☐Yes	☐No	Current Substance Use/Abuse	☐Yes	☐No
Recent Job Loss	☐Yes	☐No	Past Substance Use/Abuse	☐Yes	☐No
Victim of Violence/Abuse	☐Yes	☐No	Perpetrator of Violence/Abuse	☐Yes	☐No
DCFS Involvement	☐Yes	☐No	Homeless	☐Yes	☐No

Other (specify): _____

VI Summary/Disposition

Summary/Comments on Disposition:

☐ For telephone contacts or other non-Face-to-Face contacts: Referred to PMRT, 911, or other crisis referral
☐ For Face-to-Face contacts: Urgent need to be seen for immediate Assessment or 5150; referred for Assessment on same day as Triage
Name of Program/Assessor (if known): _____ Date: _____ Time: _____
☐ Individual in need of Assessment and/or additional linkage/referral services at this Agency
Name of Program/Assessor (if known): _____ Date: _____ Time: _____
☐ Individual actively being seen at another Agency. Referred back to Agency/Program) for Assessment or other services.
Name of Agency: _____
Telephone Call on date: _____ Name of Contact: _____ Appointment Date/Time: _____
☐ No significant impairments in life functioning AND no significant risk/safety concerns. Does not appear to meet Medical Necessity criteria.
a. ☐ Medi-Cal Beneficiary Notice of Action given on (date): _____ See attached NOA
b. ☐ Private Insurance/Indigent individual informed he/she does not meet criteria for services in our program
Other referrals/recommendations must be provided (specify referrals given):

_____
_____
_____

Signature & Discipline	Date	Co-Signature & Discipline (if required)	Date

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