MH 681 Revised 11/12/09

SFC CO-LOCATED MENTAL HEALTH TRIAGE

Page 1 of 2

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	
This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code,	
Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized Agency: Provider #:	
representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	

SFC CO-LOCATED MENTAL HEALTH TRIAGE

For telephone contacts or other non-Face-to-Face contacts: Referred to PMRT, 911, or other crisis referral More and assesser (if known); If summary/Disposition: For telephone contacts: or other non-Face-to-Face contacts: Referred to PMRT, 911, or other crisis referral Medications or Disposition: Summary/Comments on Disposition: For telephone contacts: or other non-Face-to-Face contacts: Referred to PMRT, 911, or other crisis referral More and Program/Assesser (if known); Manual contacts: Contacts: Referred to PMRT, 911, or other crisis referral More and contacts: Urgent need to be seen for immediate Assessment or 5150; referred for Assessment on other services. Manual contacts: Urgent need to be seen for immediate Assessment or S150; referred to referse to referse the contacts: Contact in Agency/Program) for Assessment or other services. Manual contact: Urgent need to be seen for immediate Assessment or S150; referred for Assessment or other services. Manual contacts: Urgent need to be seen for immediate Assessment or S150; referred for Assessment or other services. Manual contacts: Urgent need to be seen for immediate Assessment or S150; referred for Assessment or other services. Manual contacts: Urgent integrite the down or dow	IV. Psychiatric History		
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 V. Current Risk and Safety Concerns See attached DCFS Referral Form V. Current Risk and Safety Concerns See attached DCFS Referral Form V. Current Risk and Safety Concerns See attached DCFS Referral Form Ves DNO Past Thoughts of Harming Another Person Probation Involvement Ves DNO Probation Involvement Ves DNO Probation Involvement Ves DNO Probation Involvement Ves DNO Past Substance Use/Abuse Ves DNO Past Subs			
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This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, IS#:	and regulations including but not limited to applicable Welfare and Institutions code,	Name: IS#:	
Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized Agency: Provider #:			
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