MH 679
Revised 8/13/18

MENTAL HEALTH TRIAGE

***It is not necessary to complete every question on this form. Practitioners may ask the minimum amount of questions required to determine how quickly the individual needs to be seen for a Mental Health Assessment**

I. Initial Contact Data

Date: __________ **Time:** __________ **Telephone Contact:** ☐ **Face to Face:** ☐
Interviewed: ☐ Individual and/or ☐ Other (name and relationship): ____________________________________

II. Current Risk and Safety Concerns

Suicide Screening

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
2. Within the past 30 days, have you actually had any thoughts of killing yourself? ☐ Yes ☐ No
   If YES to question 2, proceed to questions 3, 4, 5, and 6
   If NO to question 2, go directly to question 6
3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No
4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No
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
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: ____

Other Safety/Risk Factors

Factor			Factor		
Homeless	☐Yes	☐No	Current Thoughts of Harming Another Person	☐Yes	☐No
History of Psychiatric Hospitalizations	☐Yes	☐No	Past Thoughts of Harming Another Person	☐Yes	☐No
DCFS Involvement	☐Yes	☐No	History of Homicide/Manslaughter	☐Yes	☐No
Probation Involvement	☐Yes	☐No	History of Injuring Another Person	☐Yes	☐No
School Issues/IEP needed/IEP in place	☐Yes	☐No	Recent Job Loss	☐Yes	☐No
Recent Trauma Exposure	☐Yes	☐No	Past Substance Use/Abuse	☐Yes	☐No
Victim of Violence/Abuse/Neglect	☐Yes	☐No	Current Substance Use/Abuse	☐Yes	☐No
Current/History of Injuring Animals	☐Yes	☐No	Perpetrator of Violence/Abuse	☐Yes	☐No
Currently taking Psychotropic Medications	☐Yes	☐No	Recently ran out of Psychotropic Medications	☐Yes	☐No

Concerns about parent/caregiver mental health or ability to deal with current stressors (specify below) ☐Yes ☐No
Concerns about eating/weight gain/Failure to Thrive (specify below) ☐Yes ☐No

Other (specify): ____

III. Additional Information on Above

Additional information on responses above that assists in determining how quickly the person needs to be seen

Current Medications including non-psychiatric (include pertinent information such as medication names, compliance, and effects of discontinuation if applicable):

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

VI Disposition

☐ Crisis Referral to Outside Agency
☐ Referred for Urgent Assessment today
☐ Referred for Assessment today
☐ Assessment Appointment Scheduled
☐ Referred to System Navigator
☐ Referred to an Outside Agency/Program
☐ No Appointment/Referral Made

Other Referrals/Recommendations Provided (specify referrals given):

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

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 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.

Name: **IBHS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health