ADULT MENTAL HEALTH TRIAGE

I. Initial Contact Data:

Date: _____ **Time:** _____ **Telephone Contact (Sections I-VI):** ☐ **Face to Face:** ☐
Interviewed: ☐ Individual and/or ☐ Other (name and relationship): _____
Adults: Individual is responsible for ☐ Dependent Child(ren) ☐ Dependent Adult ☐ Self Only
If dependent(s), specify age and any disability: _____
Household Constellation (adults/children/pets): _____

Referral Source (list contact info if available):

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 did the person come in today? (In his/her own words)

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 ☐ 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

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IV. Psychiatric History

How long has this presenting situation been a problem?

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

Individual reports presenting to any Mental Health agency previously (DMH agency/contract, private, other)?
☐ Yes ☐ No ☐ Unknown If yes, specify

Individual reports being released from a psych hospital, jail/juvenile hall, Mental Health Res facility within the past 7 days?
☐ Yes ☐ No If yes, specify

Current Medications including non-psychiatric (list Names and other pertinent information such as compliance with meds):

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

V. Current Risk and Safety Concerns

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 (only to be completed if above information completed by Non-AMHD or over the telephone)

Summary/Comments on Disposition:

☐ For telephone contacts, Individual referred to PMRT, 911, or other crisis referral
☐ 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: _____
☐ For face-to-face contacts, Individual referred to AMHD for completion of Triage on same day as non-AMHD Triage
Name of Program/Assessor (if known): _____ Date: _____ Time: _____
☐ Individual referred for Assessment at this Agency
Name of Program/Assessor (if known): _____ Date: _____ Time: _____
☐ Referred to (name of Agency/Program): _____
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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The following sections shall only be completed by an AMHD and for Face-to-Face contacts

VII. Mental Status: Check as many boxes as apply.

Grooming & Hygiene: ☐Average
☐Well Groomed ☐Dirty ☐Odorous
☐Disheveled ☐Bizarre
Eye Contact: ☐Normal for culture
☐Little ☐Avoids ☐Erratic
Motor Activity: ☐Calm
☐Restless ☐Agitated ☐ Tremors/Tics
☐Posturing ☐Rigid ☐Retarded ☐Akathesis
Speech: ☐Unimpaired
☐Soft ☐Slowed ☐Mute ☐Pressured
☐Loud ☐Excessive ☐Slurred
☐Incoherent ☐Poverty of Content
Interactional Style: ☐ Culturally Congruent
☐Guarded/Suspicious ☐Aggressive
☐Uncooperative ☐Demanding ☐Belligerent
Orientation: ☐Oriented
☐Disoriented to:
☐Time ☐Place ☐Person ☐Situation
Intellectual Functioning: ☐Unimpaired
☐Impaired

Memory: ☐Unimpaired ☐Impaired
Mood: ☐ Euthymic ☐ Dysphoric ☐Tearful
☐Irritable ☐Lack of Pleasure
☐Hopeless/Worthless ☐Anxious
☐Known Stressor ☐Unknown Stressors
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
☐Confabulous ☐Flight of Ideas ☐Word Salad

Thought Content Disturbance
Concentration: ☐Intact ☐Impaired
Judgments: ☐Intact ☐Impaired
Insight: ☐Adequate ☐Impaired:
Delusions: ☐ None Apparent
☐Persecutory ☐ Paranoid ☐Grandiose
☐Somatic ☐ Religious ☐Nihilistic
☐Being-Controlled
Ideations: ☐None Apparent
☐ Apparent Specify Type: _____
Suicidal:☐Denies Ideation ☐Threatening☐Plan
Homicidal: ☐Denies Ideation
☐Threatening ☐Plan
Other: ☐Disorganized ☐Bizarre
☐Ritualistic ☐Obsessive/compulsive
Comments on Mental Status:

VIII. Clinical Summary/Disposition

Summary/ Clinical Impression:

Disposition/Recommendations/Plan:
Must choose from 1, 2 or 3. For Options 2 and 3, an additional disposition must be marked.

1. ☐ Urgent need to be seen for **immediate** Assessment or 5150; continued with or referred for Assessment on same day as Triage
   Name of Program/Assessor (if known): _____ Date: _____ Time: _____
2. ☐ Individual has significant impairments in life functioning OR significant risk/safety concerns.
   a. ☐ Triage suggests individual needs to be seen in timely manner to avoid deterioration to an urgent condition; referred to Assessment on same day as Triage
      Name of Program/Assessor (if known): _____ Date: _____ Time: _____
   b. ☐ Individual is appropriate to be seen by this Agency
      i. ☐ Continue with non-urgent/crisis Assessment on same day as Triage
         Name of Program/Assessor (if known): _____ Date: _____ Time: _____
      ii. ☐ Appointment made for Assessment
         Name of Program/Assessor (if known): _____ Date: _____ Time: _____
   c. ☐ This Agency does not have an appropriate Program available
      i. ☐ Referred to System Navigator (Name):_____ Telephone Call on date: _____
      ii. ☐ Referred to (name of Agency/Program): _____
         Telephone Call on date: _____Name of Contact: _____
         Appointment Date/Time: _____
3. ☐ 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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