CHILD 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): ______________________
Children: Individual resides with ☐ Biological parent(s) ☐ Adoptive Parent ☐ Foster Parent ☐ Other ____________
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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Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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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: ☐ Clean ☐ Dirty ☐ Odorous ☐ Disheveled
Nutrition/Build: ☐ Normal ☐ Thin ☐ Heavy ☐ Obese ☐ Pre-Pubertal ☐ Post-Pubertal
Eye Contact: ☐ Normal for culture ☐ Little ☐ Avoids ☐ Erratic ☐ Piercing ☐ None
Gross Motor: ☐ Intact ☐ Impaired
Fine Motor: ☐ Intact ☐ Impaired
Motor Activity: ☐ Normal for age ☐ Hyperactive ☐ Hypoactive ☐ Fidgety ☐ Lethargic ☐ Mannerisms ☐ Tics
Relatedness to Caretaker: ☐ Not Observed ☐ Appropriate ☐ Clinging ☐ Defiant ☐ Disobedient ☐ Bossy
Response to Examiner: ☐ Friendly ☐ Cooperative ☐ Indifferent ☐ Anxious ☐ Withdrawn ☐ Seductive ☐ Oppositional ☐ Aggressive ☐ Crying ☐ Temper Tantrum
Speech/Language: ☐ Unimpaired ☐ Spontaneous ☐ Normal Volume ☐ Loud Volume ☐ Soft Volume ☐ Responds only to ?s ☐ Mute ☐ No receptive language ☐ Hyperverbal ☐ Articulation Defects ☐ Slurred ☐ Pressured ☐ Echolalia ☐ Bizarre utterances

Orientation: ☐ Oriented ☐ Disoriented to: ☐ Time ☐ Place ☐ Person ☐ Situation
Attention/Concentration: ☐ Satisfactory ☐ Fair ☐ Poor ☐ Not determined
Distractibility: ☐ Age Appropriate ☐ Highly Distractible
Memory: ☐ Unimpaired ☐ Impaired
Mood: ☐ Euthymic ☐ Sad ☐ Tearful ☐ Irritable ☐ Fearful ☐ Anxious ☐ Angry ☐ Silly ☐ Euphoric
Affect: ☐ Normal ☐ Labile ☐ Expansive ☐ Restricted ☐ Blunted ☐ Flat

Perceptual Disturbance
Hallucinations: ☐ None Apparent ☐ Visual ☐ Auditory

Thought Process Disturbances
☐ None Apparent
Associations: ☐ Unimpaired ☐ Loose ☐ Tangential ☐ Circumstantial ☐ Confabulous ☐ Flight of Ideas ☐ Word Salad

Comments:

Behavioral Disturbances: ☐ None Apparent ☐ Aggressive ☐ Violent ☐ Destructive ☐ Isolative ☐ Self-Destructive ☐ Poor-Impulse Control ☐ Avoidant ☐ Manipulative ☐ Intrusive ☐ Demanding ☐ Uncooperative ☐ Passive ☐ Not Motivated

Thought Content Disturbance
Content: ☐ Appropriate ☐ Fears ☐ Worries ☐ Bizarre Ideation ☐ Excessive Worry
Concentration: ☐ Intact ☐ Impaired
Judgments: ☐ Intact ☐ 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
Evasive Other Disturbances: ☐ Disorganized ☐ Bizarre ☐ Ritualistic ☐ Obsessive/compulsive ☐ Compulsive ☐ Silly ☐ Excessive Crying
Process: ☐ Goal Directed ☐ Magical Thinking ☐ Circumstantial ☐ Loose Associations ☐ Flight of Ideas ☐ Rumination ☐ Planning ☐ Evasive

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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