

COMMUNITY PROVIDER
UNIFORM SCREENING AND REFERRAL FORM
FOR CHILDREN AND ADOLESCENTS

C&A

Agency: GGG
SASS Agency: GGG
Screener: ID: GGG Date: GG GG GG
Month Day Year
Location/Setting of Screening: GG County: GGG
Begin Time: GG:GG AM End Time: GG:GG AM Total Time: GGG Minutes
Brought By: Referral Source: GG

IDENTIFYING INFORMATION Please Print
DMHDD ID# GGGGGGGGGG
Agency Client I.D.# GGGGGGGGGG
First M/I Last
Address DOB: GG GG GG Sex: GG
MONTH DAY YEAR M F
City/State Zip Age
Phone # GGG-GGG-GGGG SS # GGG-GG-GGGG
Marital Status: G Never Married G Married G Other Status
Ethnic Group: G White G African American G Hispanic G Native American G Asian G Other
Parent/Guardian: Household Size Including Individual: GG
Address: Phone #: -
If DCFS Ward, DCFS ID#: DCFS Caseworker
DCFS Supervisor: Phone #: -
DCFS Office/Address: /
Preferred Language: Current Housing Situation: GG
Legal Charges:
Involvement with other MH Provider Active? G Yes G No G Unknown
Case Manager Name:
Other Agency Involvement: Contact Person:

Income Source: Insurance Info: Tentative Diagnosis(es)
G Public Aid G Private/HMO
G SSI G Medicaid
G Parent's Employment G VA Benefits
G Other G Other
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FACE TO FACE INTERVIEW

NAME: _____

1. Presenting problem, including [precipitating event(s), stressors, duration of problem]. (Attach additional pages if necessary) _____

2. Mental health history [Include: present and prior inpatient and outpatient services, dates of services, agency/hospital, legal/corrections history, and treatment-placement history. Also include: DCFS placement history, DCFS, court and school involvement]. (Attach additional pages if necessary.)

List other agencies/therapists involved below:

3. Alcohol/substance abuse history, including present and past treatment interventions.

4. Present physical condition, physical distress, past problems, allergies and current medications. Clarify source of information, i.e., client report, ER Physician evaluation, etc. (Attach lab work, ER report(s), etc.)

5. MENTAL STATUS

General Appearance: physical structure (small, average, large), obese, slim, well-groomed, inappropriate dress, poor hygiene, unkempt. Posture (stooped, stiff, bizarre, appropriate), physical deformity, other: _____
Remarks _____

Manner and attitude: critical, suspicious, disinterested, irritable, threatens violence, assaultive, physically destructive, withdrawn, impulsive, argumentative, other: _____
Remarks _____

Motor activity: hyperactive, hypoactive, tremors, tics, speech defects, paralysis, posturing, other: _____
Remarks _____

Mood or affect: elated, blunted, flat, apathetic, calm, inappropriate, dysphoric, anxious, labile, fearful, depressed, worried, angry, other: _____
Remarks _____

Thought processes: latency of response, blocking, tangential answers, perseveration, flight of ideas, loose associations, incoherency, abnormal perceptions--illusions, hallucinations (auditory, visual, tactile, other), other: _____
Remarks _____

Thought content: ideas of reference, delusions, paranoid trends, hypochondriasis, phobias, obsessions, compulsions, suicidal ideation, bizarre thoughts, depersonalization, derealization, other: _____
Remarks _____

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6. CURRENT FUNCTIONING

Describe child's functioning in the following domains:

	Not Applicable	Significant Problems	Some Problems	No Problems	Areas of Strength
Basic Needs	[]	[]	[]	[]	[]
Physical/Medical Needs	[]	[]	[]	[]	[]
Substance Abuse	[]	[]	[]	[]	/
Social/Recreational	[]	[]	[]	[]	[]
School	[]	[]	[]	[]	[]
Psychological	[]	[]	[]	[]	[]
Family	[]	[]	[]	[]	[]
Legal	[]	[]	[]	[]	/
Vocational	[]	[]	[]	[]	[]

Describe child's current family/caregiver context(s), i.e, persons living in the household, relationship to child, significant stressors affecting caregiving to the child.

7. Clinical Judgment of Dangerousness

IMMINENT DANGER OF HARM TO SELF _____ Present _____ Absent

Describe specific behaviors, threats, ideation, plan, etc: _____

IMMINENT DANGER OF HARM TO OTHERS _____ Present _____ Absent

Describe specific behaviors, threats, ideation, plan, etc: _____

*****IF CHILD OR ADOLESCENT IS A WARD OF DCFS, THE RISK ANALYSIS FORM MUST BE COMPLETED AND ATTACHED.**

8. Diagnostic Impression

Axis I _____ . _____
 Axis II _____ . _____
 Axis III _____ . _____
 Axis IV _____ . _____
 Axis V _____ . _____

9. Comments (optional) _____

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SCREENING DISPOSITION

1. Community Alternative

2. Community Resources to be Utilized:

A. Provided by SASS Program (specify agency):

B. Provided by other mental health or child serving agency (specify agency):

3. SOF Admission

Rationale for SOF admission:

Treatment plan recommendations:

Anticipated discharge setting:

Continuity of Care Service Agency if known _____

Recommendations of SASS screener explained to:

Client ___Yes ___No Client Signature _____

Parent/Caregiver ___Yes ___No Parent/Caregiver Signature _____

Referral Source ___Yes ___No

Review of Alternative Treatment Options and Rationale for SOF Admission. Include reasons why a community hospital is not able to provide for this individual

Signature of SASS Screener: _____ Date _____

Print Name _____

Signature of SASS QMHP: _____ Date _____

Print Name _____