**MENTAL HEALTH SCREENING FORM**

**I. IDENTIFYING DATA Screen Urgency**       **Tracking #**

|  |  |
| --- | --- |
| **QMHP/LMHP**       | **Location of Interview** Tele video- |
| **Screen Date**       | **Screen Start Time**      [ ] **AM/** [ ]  **PM** | **Screen Decision Time**      [ ]  **AM/** [ ]  **PM** |
| **Screening CMHC/LMHP**  |
| **Courtesy Screen** [ ] **No** [ ]  **Yes**  | **CMHC**       | **Staff**       | **Date**       |
| [ ]  **Inpatient Rescreen** | **Date**       | **QMHP**       |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|       |       |      |
| **Name: Last** | **First** | **MI** |
|       |       |
| **Pre-Marital Name** | **Also Known As (AKA)** |
|  |  |
| **Street Address**  |       |
|  |  |
| **City, State, Zip** |       |
|  |  |
| **Phone** |       |
|  |  |
| **County of Residence** |       |
|  |  |
| **County of Responsibility** |       |
|  |  |
| **SSN** |       |
|  |  |  |  |  |  |
| **DOB** |       | **Age** |       | **Gender** |       |
|  |  |
| **Current outpatient treatment order:** | [ ] Yes [ ] No [ ] UK |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Referred by** |       |
| **Consumer Status** |  |
| [ ] Current CMHC Consumer | [ ] Former CMHC Consumer |
| [ ] Other CMHC Consumer | [ ] Never a CMHC Consumer |
| [ ] Private Provider |       |
| **Screening Informants** |  |
| [ ] Family |       |
| [ ] CMHC/Private Provider  |       |
| [ ] Hospital Staff  |       |
| [ ] JJA/Contractor  |       |
| [ ] LEO/Other Agency |       |
| [ ] Other |       |
| **Child Custody Status** |  |
| [ ] Parental | [ ] SRS |
| [ ] JJA | [ ] Contractor |       |
| **Type of Screening Completed** |
| [ ] State Hospital |
| [ ] Medicaid Inpatient Psychiatric |
| [ ] State Hospital Alternative | [ ] **Prairie Ridge STAR** | [ ] **Wheatland** |
| [ ] PRTF | [ ] **Emergency Exception** | [ ]  **Initial** | [ ] **Extension** |

**II. PSYCHOSOCIAL ASSESSMENT: Guardian** [ ]  **Yes** [ ]  **No** **Name/Address/Phone #:**

**This individual has others involved in helpful way (circle):** **Parent, Family, Friends, Case Worker, Neighbor, Landlord, Other**

**Name/Address/Phone #:**

**Name/Address/Phone #:**

**This Individual:** [ ] **Has adequate support systems** [ ] **Has limited support systems** [ ] **Has no support systems**

 [ ] **Stable living environment** [ ] **Unstable Living Environment** [ ]  **Homeless** [ ]  **Currently Incarcerated**

[ ] **Receiving MR/DD services** – **Agency/Case Worker Name/Phone #:**

**Armed Forces:** [ ] **Veteran** [ ]  **Active** [ ]  **Inactive**  [ ]  **None** **Period(s) of Service:**

**Additional Information/Clarification regarding psychosocial supports, conflicts, stressors concerns, housing etc.**

**FINANCIAL RESOURCES:** [ ] **Employed** [ ]  **Unemployed**  [ ]  **Disabled** [ ]  **Student Other:**

**Third Party Payer(s)** **Medicaid ID#**

 [ ]  **Pending Medicaid** **Medicare ID #**

**Other ID#/Group #/Responsible Party**       **VA Benefits** [ ]  **Yes** [ ]  **No**

**III. PRESENTING PROBLEM(S)**

[ ] **Current Danger** [ ]  **Potential Danger to SELF** [ ] **Self Care Failure** [ ]  **Substance Abuse**

[ ] **Current Danger** [ ]  **Potential Danger to OTHERS** [ ] **Psychotic Symptoms** [ ]  **Conduct/Behavior**

[ ] **Current Danger** [ ]  **Potential Danger to PROPERTY** [ ] **Mood Disorder** [ ]  **Other**

**Consumer Statement of Concern(s) (In his/her own words):**

**IV. RISK FACTORS** **Name:**

**Current Danger to Self:** [ ] **None** [ ]  **Ideation** [ ]  **Plan** [ ]  **Threat** [ ]  **Intent with Means** [ ]  **Intent w/o Means**

[ ] **Self Care Failure** [ ]  **Gesture/Attempt** [ ]  **Risk aggravated by substance use** [ ]  **At Risk**

**Explain (Include dates, means, rescue)**

**History of Danger to Self:** [ ] **None** [ ]  **Ideation** [ ]  **Plan** [ ]  **Threat** [ ]  **Intent with Means** [ ]  **Intent w/o Means**

[ ]  **Self Care Failure** [ ]  **Gesture/Attempt** [ ]  **Risk aggravated by substance use**

**Explain (Include dates, means, rescue)**

**History of family members or significant acquaintances that attempted or completed suicide** [ ]  **Yes** [ ]  **No** [ ]  **Unknown**

**Explain**

**Current Danger to Others:** [ ]  **None** [ ]  **Ideation** [ ]  **Plan** [ ]  **Threat** [ ]  **Intent with Means** [ ]  **Intent w/o Means**

[ ]  **Gesture/Attempt** [ ]  **Risk aggravated by substance use** [ ]  **At Risk**

**Explain (Include dates, means)**

**History of Danger to Others:** [ ]  **None** [ ]  **Ideation** [ ]  **Plan** [ ]  **Threat** [ ]  **Intent with Means** [ ]  **Intent w/o Means**

[ ]  **Gesture/Attempt** [ ]  **Risk aggravated by substance use** [ ]  **Physical Aggression**

**Explain (Include dates, means)**

**Current Destruction of Property:** [ ] **YES** [ ]  **NO** [ ]  **UNK History of Destruction of Property:** [ ] **YES** [ ]  **NO** [ ]  **UNK**

**Explain**

**Current Abuse:** [ ] **YES** [ ]  **NO** [ ]  **UNK TYPES:** [ ] **Physical** [ ]  **Sexual** [ ]  **Emotional** [ ]  **Neglect** [ ]  **History Reported**

**If yes, individual is:** [ ]  **Victim** [ ]  **Perpetrator** [ ]  **Both** [ ]  **Neither, but abuse reported in environment**

**Explain**

**SUBSTANCE USE/ADDICTIONS: Indication of Current/History of Substance Use** **[ ]  Yes** **[ ]  No** **[ ]  Unknown**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug/Type** | **Amount** | **Frequency** | **Last Use/Dose** |
| **Drug of choice:**       |       |       |       |
| **Secondary:**       |       |       |       |
| **Tertiary:**       |       |       |       |

***\*WHEN APPROPRIATE- Recommend medical consultation/evaluation to determine medical stability for transfer.***

[ ]  **Positive Lab Screen for the following:**       **BAC/BAL**       [ ]  **Not Available**

[ ]  **History of Withdrawal Symptoms/Complications with Detox?** [ ]  **Seizures** [ ]  **DT’s (Delirium Tremens)**

**Explain (Identify withdrawal symptoms, medical intervention etc):**

|  |
| --- |
| **\* GAMBLING ADDICTION:**[ ] Past [ ]  Current [ ]  Unk [ ]  N/A **INTERNET ADDICTION**: [ ] Past [ ]  Current [ ]  Unk [ ]  N/A |

**Substance Treatment History:**

|  |  |  |
| --- | --- | --- |
| **Type of Treatment** | **Agency** | **Month/Year** |
|       |       |       |
|       |       |       |

**Additional information/clarification of Substance/Addiction Concerns** (Including collateral concerns, interaction of substances with mental health symptoms, etc)**:**

PAGE 2

**Name:**

**MEDICAL:** [ ]  **None by Client Report** [ ]  **Self/Family Report** [ ]  **Physician/Nurse Report** [ ]  **Medical Records**

**Current Medical Conditions/Concerns (Check those that apply):**

[ ]  **Unknown** [ ]  **Diabetes-Insulin** [ ]  **Yes** [ ]  **No** [ ]  **Kidney Disease/UTI**

[ ]  **Pregnant Wks:**     [ ]  **History of Dementia Diagnosis** [ ]  **History of Traumatic Brain Injury**

[ ]  **Seizure Disorder** [ ]  **Other:**

[ ]  **NKDA** [ ]  **Drug/Food Allergies:**

**List Current Medications:** Specify Name & Dosage (Include Psychiatric & Non-Psychiatric Medications)

**Taking as Directed: (Y) Yes (N) No (U) Unknown** **Y N U**  **Y N U**

|  |  |  |  |
| --- | --- | --- | --- |
|       | [ ] [ ]  [ ]  |       | [ ] [ ]  [ ]  |
|       | [ ] [ ]  [ ]  |       | [ ] [ ]  [ ]  |
|       | [ ] [ ]  [ ]  |       | [ ] [ ]  [ ]  |
|       | [ ] [ ]  [ ]  |       | [ ] [ ]  [ ]  |
|       | [ ] [ ]  [ ]  |       | [ ] [ ]  [ ]  |

**Psychiatric Provider/Location:**

**Primary Care Physician/Location:**

**Comments regarding reported medical issues (i.e. Medication Compliance, Current Medical Treatment, etc):**

 **\*Special Medical Considerations:**[ ]  **N/A**[ ]  **Self/Family Report** [ ]  **Physician/Nurse Report** [ ]  **Medical Records** [ ]  **Unknown**

 *“Do you need or use any of the following medical equipment or treatment?”*

[ ] Oxygen Equipment [ ] Ventilator [ ] Wound care

[ ] Foley or Catheters, Dialysis [ ] Insulin pump [ ] Surgery/Post-operative care

[ ] Intravenous ports or permanent venous access [ ] Current cancer treatment

[ ] IV medications, care or services

***“Do you require assistance with any of the following?”***

[ ] Getting out of bed [ ] Toileting [ ] Feeding [ ] Moving [ ] Using wheelchair

 **Comments/other:**

**V. TREATMENT/PLACEMENT INFORMATION**
**Currently in treatment:** [ ] **Yes** [ ]  **No** [ ]  **Unknown** **Therapist/Case Manager:**

**Agency/Provider/Service(s):**

**Service Progress/Failure:**

**Previously Hospitalized:** [ ] **Yes** [ ]  **No** [ ]  **Unknown** **Multiple Hospitalizations:** [ ] **Yes x**      [ ]  **No** [ ]  **Unknown**

**Last Psychiatric Hospitalization:**       **Date Admitted**       **Date Dismissed**       [ ]  **AMA**

**Other Psychiatric Hospitalizations:**

**PRTF Treatment History (Include Dates if Known):**

**Legal History:**

**Current/History of Legal Contacts/Problems:** [ ] **Yes** [ ]  **No** [ ]  **Unknown Charges Pending:** [ ] **Yes** [ ]  **No** [ ]  **Unknown**

[ ] **Probation x**      [ ]  **Parole x**      [ ]  **Incarcerations/Detention x**

[ ] **CINC x**      [ ]  **JO x**       [ ]  **Foster Care x**        [ ]  **YRC x**        [ ]  **Other**       [ ]  **Not Applicable**

**Explain:**

**Education Status: Name of School**       **Highest Grade Completed**

[ ]  **Regular Education** [ ]  **Special Education** - **Category (if known):**

PAGE 3

**Name**:

**VI. CLINICAL IMPRESSIONS (where two choices are offered, circle appropriate choice)**

**General Appearance**

[ ] Appropriate hygiene/dress

[ ] Poor personal hygiene

[ ] Overweight [ ]  Underweight

[ ] Eccentric  [ ]  Seductive

**Sensory/Physical Limitations**

[ ] No limitations noted

[ ] Hearing [ ] Visual

[ ] Physical [ ] Speech

**Mood**

[ ] Calm [ ] Euthymic

[ ] Cheerful [ ] Anxious

[ ] Depressed [ ] Fearful

[ ] Suspicious [ ] Labile

[ ] Pessimistic [ ] Irritable

[ ] Euphoric [ ] Hostile

[ ] Guilty [ ] Apathetic

[ ] Dramatized [ ] Hopelessness

[ ] Elevated mood

[ ] Marked mood shifts

**Affect**

[ ] Primarily appropriate

[ ] Primarily inappropriate

[ ] Congruent [ ] Incongruent

[ ] Constricted [ ] Tearful

[ ] Blunted [ ] Flat

[ ] Detached

**Speech**

[ ] ***Unable to assess***

[ ] Logical/Coherent [ ]  Loud

[ ] Delayed responses [ ]  Tangential [ ]  Rambling  [ ]  Slurred

[ ] Rapid/Pressured

[ ] Incoherent/loose associations

[ ] Soft/Mumbled/Inaudible

**Thought Content/Perceptions**

[ ] ***Unable to assess*** [ ] Delusions

[ ] No disorder noted [ ] Grandiose

[ ] Paranoid [ ] Racing

[ ] Circumstantial [ ] Obsessive

[ ] Disorganized [ ] Flight of ideas

[ ] Bizarre [ ] Blocking

[ ] Ruminations/Intrusive Thoughts

[ ] Auditory Hallucinations

[ ] Visual Hallucinations

[ ] Other hallucinatory activity

[ ] Ideas of reference

[ ] Illusions/Perceptual Distortions

[ ] Depersonalization/Derealization

**Memory**

[ ]  ***Unable to assess-***

[ ] No impairment noted

[ ] Impaired Immediate

[ ] Impaired remote

[ ] Impaired recent

**Insight (Age Appropriate)**

[ ] ***Unable to assess-***

[ ] Good [x]  Fair

[ ] Poor [ ] Lacking

**Orientation**

[ ] ***Unable to assess*** [x]  Oriented x 4

[ ] Impaired time [ ]  Imp. situation

[ ] Impaired place [ ]  Impaired person

**Cognition/Attention**

[ ] ***Unable to assess***

[ ] No impairment noted

[ ] Distractibility/Poor Concentration

[ ] Impaired abstract thinking

[ ] Impaired judgment

[ ] Indecisiveness

**Behavior/Motor Activity**

[ ] ***Unable to assess***

[ ] Normal/Alert [ ] Poor eye contact

[ ] Cooperative [ ]  Uncoordinated

[ ] Self-Destructive [ ] Catatonic

[ ] Lethargic [ ] Tense

[ ] Agitated [ ] Withdrawn

[ ] Restless/Overactive[ ]  Provocative

[ ] Impulsiveness [ ] Tremors/Tics

[ ] Aggression/Rage [ ]  Repetitious

[ ] Peculiar mannerisms

[ ] Bizarre behavior

[ ] Indiscriminate socializing

[ ] Disorganized behavior

[ ] Feigning of symptoms

[ ] Avoidance behavior

[ ] Increase in social, occupational,

 sexual activity

[ ] Decrease in energy, fatigue

[ ] Loss of interest in activities

[ ] Compulsive (including gambling/internet)

**Eating/Sleep Disturbance**

[ ]  ***Unable to assess***

[ ] No disturbance noted

[ ] Decreased/Increased appetite

[ ] Binge eating

[ ] Self-induced vomiting

[ ] Weight gain/loss (     lbs/time     )

[ ] Hypersomnia/Insomnia

[ ] Bed-wetting

[ ] Nightmares/Night Terrors

**Anxiety Symptoms**

[ ]  ***Unable to assess***

[ ] Within normal limits

[ ] Generalized anxiety

[ ] Fear of social situations

[ ] Panic attacks

[ ] Obsessions/Compulsions

[ ] Hyper-vigilance

[ ] Reliving traumatic events

**Conduct Disturbance**

[ ]  ***Unable to assess***

[ ] Conduct appropriate

[ ] Stealing [ ]  Lying

[ ] Projects blame [ ]  Fire setting

[ ] Short-tempered

[ ] Defiant/Uncooperative

[ ] Violent behavior

[ ] Cruelty to animals/people

[ ] Running away [ ] Truancy

[ ] Criminal activity [ ] Vindictive

[ ] Argumentative

[ ] Antisocial behavior

[ ] Destructive to others or property

**Occupational & School Impairment**

[ ] ***Unable to assess***

[ ] No impairment noted

[ ] Impairment grossly in excess than

 expected in physical finding

[ ] Impairment in occupational

 functioning

[ ] Impairment in academic

 functioning

[ ] Not attending school/work

**Interpersonal/Social Characteristics**

[ ]  ***Unable to assess***

[ ] No significant trait noted

[ ] Chooses relationships that lead to

 disappointment

[ ] Expects to be exploited or harmed

 by others

[ ] Indifferent to feelings of others

[ ] Interpersonal explosiveness

[ ] No close friends or confidants

[ ] Unstable and intense relationships

[ ] Excessive devotion to work

[ ] Inability to sustain consistent work behavior

[ ] Perfectionistic [ ]  Grandiose

[ ] Procrastinates [ ]  Entitlement

[ ] Persistent emptiness & boredom

[ ] Constantly seeking praise or

 admiration

[ ] Excessively self-centered

[ ] Avoids significant interpersonal

 contacts

[ ] Manipulative/Charming/Cunning

NOTES:

PAGE 4

**Name:**

**VII. CLINICAL SUMMARY AND DIAGNOSTIC IMPRESSIONS**

(Include medical necessity, consideration of resources, treatment alternatives, etc)

 **DIAGNOSTIC CODE DIAGNOSES 🗸 PRIMARY**

|  |  |  |
| --- | --- | --- |
| **AXIS I:** |  |  |[ ]
|  |       |  |[ ]
|  |       |  |[ ]
|  |       |  |[ ]
|  |       |  |[ ]
| **AXIS II:** |       |  |[ ]
|  |       |  |[ ]
| **AXIS III:** |       |
|  |  |
| **AXIS IV:** |       |
|  |  |
| **AXIS V:** | **CURRENT GAF:** |  | **HIGHEST PAST YEAR:** |  |

**KHS SPECIAL HEALTH CARE NEEDS:**

[ ]  **SED** [ ]  **SPMI** [ ]  **SMI** [ ]  **Unknown** [ ]  **N/A**

[ ]  **MR/DD** [ ]  **Pregnant & Using Substances** [ ]  **Substance Use & Mental Illness** [ ]  **IV Drug User & Mental Illness**

**\*Clinical impression, diagnoses, and recommendations have been shared with consumer, parents and/or guardian (unless contraindicated).**

**VIII. TIME DOCUMENTATION SUMMARY (Include Travel Time):**

**Contact/Activity Amount of Time Rescreen in 5 days**

[ ] Chart Review:

[ ] Paperwork:

[ ] Face-to-Face Interview:

[ ] Coordination of Admission:

[ ] Collateral Contacts:

[ ] Consultation/Team Meetings:

**Total Screen Time:**      **Hrs**       **Min****Hrs** **Min**

**Travel Time To/From:** **Hrs** **Min** **Hrs** **Min**

**Total Time:**      **Hrs**      **Min** **Hrs** **Min**

***\*Continue to page 6A to complete Medicaid disposition, page 6B for State Hospital screening disposition, or 6C for PRTF Disposition.***

PAGE 5

**Name:**

**IX. *COMPLETE FOR MEDICAID INPATIENT PSYCHIATRIC,***

***KVC PRAIRIE RIDGE STAR, and KVC WHEATLAND SCREENS***

**INPATIENT CRITERIA**

**Level I, Independent: Criteria which, in and of themselves, MAY constitute justification for admission.**

[ ]  1. Suicide attempt, threats, gestures indicating potential danger to self.

[ ]  2. Homicidal threats or other assaultive behavior indicating potential danger to others.

[ ]  3. Extreme acting out behavior indicating danger or potential danger to property.

[ ]  4. Self-care failure indicating an inability to manage daily basic needs that may cause self-injury.

**Level 2, Dependent: Clinical characteristics of psychiatric disorders, any of which in combination with at least ONE**

 **Level 3 criterion, MAY constitute justification for admission.**

[ ]  5. Clinical Depression.

[ ]  6. Intense anxiety or panic that may cause injury to self or others.

[ ]  7. Loss of reality testing with bizarre thought processes such as paranoia, ideas of reference, etc.

[ ]  8. Impaired memory, orientation, judgment, incoherence, or confusion.

[ ]  9. Impaired thinking, and/or affect accompanied by auditory or visual hallucinations.

[ ]  10. Mania or Hypomania.

[ ]  11. Mutism or catatonia.

[ ]  12. Somatoform disorders.

[ ]  13. Severe eating disorders such as bulimia or anorexia.

[ ]  14. Severely impaired social, familial, academic, or occupational functioning, which may include excessive use of substances.

[ ]  15. Severe maladaptive or destructive behaviors in school, home, or placement, which may include excessive use of substances.

[ ]  16. Extremely impulsive and demonstrates limited ability to delay gratification.

**Level 3, Contingent: Acute-care program needs which MAY justify psychiatric hospital admission.**

[ ]  17. Need for medication evaluation or adjustment under close medical observation.

[ ]  18. Need for 24-hour structured environment due to inability to maintain treatment goals or stabilize in less

 intensive levels of care.

[ ]  19. Need for continuous secure setting with skilled observation and supervision.

[ ]  20. Need for 24-hour structured therapeutic milieu to implement treatment plan.

**DISPOSITION/REIMBURSEMENT AUTHORIZATION**

[ ]  **(A.) Meets inpatient criteria; Hospitalization recommended.** [ ]  **Voluntary** [ ]  **Involuntary**

 **Admitted/transferred/referred to hospital**       **Admission Date**

**Treatment Expectations/Preliminary Discharge Plan**

[ ]  **(B.) Alternative community services plan recommended in lieu of hospitalization, copy given to legally responsible individual.**

[ ]  **(C.) Does not meet inpatient criteria. Alternative community services plan recommended, copy given to legally responsible individual.**

**Comments:**

I certify that local community resources have been investigated and or consulted to determine whether or not any of them can furnish appropriate and necessary care. I have seen this individual and evaluated him/her and his/her situation. I have also considered alternative modes of treatment. Available community resources have been investigated, and are not appropriate if hospitalization is recommended.

Signature of QMHP designated as a member of MHC Screening Team Date

PAGE 6A

 **Name:**

**X. *COMPLETE FOR STATE HOSPITAL ADMISSION***

**ADMISSION CRITERIA** – Symptoms that interfere with the consumer’s ability to care for themselves and/or dependents outside of the structure of a psychiatric hospital. **Criteria which, in and of themselves, MAY constitute justification for admission.**

**Cognitive** [ ] Paranoid Ideations [ ] Ideas of Reference [ ] Loss of Reality Testing

[ ] Disorientation to Time, Place, Person, or Situation [ ] Disorganization, Confusion or Incoherence

[ ] Other/Explain:

**Perceptual** [ ] Auditory Hallucinations [ ] Visual Hallucinations [ ] Inability to recognize familiar people

[ ] Other/Explain:

**Emotional** [ ] Severe anger likely to cause a suicide attempt [ ] Anger/rage - provokes thoughts of harming others

[ ] Unusual fear, anxiety and/or panic that is likely to cause self injury

[ ] Other/Explain:

**Behavioral** [ ] Suicidal threats/serious attempts to harm self [ ]  Homicidal threats/serious attempts to harm others

[ ] Self Care Failure [ ]  Mutism or Catatonia [ ]  Mania or hypomania

[ ] Conduct Disturbance:

[ ] Other/Explain:

**SCREENING DISPOSITION**

[ ] (**A.) Admission Recommended**

1. [ ] Recommended **VOLUNTARY** admission to       State Hospital.
	* 1. [ ] Recommended **INVOLUNTARY** admission to       in accordance with KSA Statutes.

**(Must meet criteria 1, 2, and 3, plus 4 and/or 5 below)**

[ ] 1. Is suffering from a severe mental disorder to the extent that he/she needs involuntary care in a State Hospital.

1. [ ] 2. Lacks the capacity to make an informed decision concerning his/her need for treatment.

[ ] 3. Is not manifesting a primary diagnosis of antisocial personality disorder, chemical abuse/addiction, mental

 retardation, organic personality syndrome, or an organic mental disorder.

[ ] 4. Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others

 or substantial damage to another’s property, as evidenced by behavior causing, attempting, or threatening such injury,

 abuse or damage; OR

[ ]  5. Is substantially unable, except for a reason of indigence, to provide for any of his/her basic needs, such as food,

 clothing, shelter, health, or safety, causing a substantial deterioration of the person’s ability to function with current

 level of support, care or structure.

[ ]  **(B.) Alternative community services plan recommended in lieu of state hospitalization, copy given to legally responsible individual.**

1. [ ]  Recommended **involuntary outpatient commitment** to      .

[ ]  **(C.) Does not meet state hospital criteria. Alternative community services plan recommended, copy given to legally responsible individual.**

**Treatment Expectations:**      .

**Preliminary Discharge Plan (Housing, Legal, Finances, Supports, Services):**

**Consumer Response to Proposed Intervention:**

I certify that local community resources have been investigated and or consulted to determine whether or not any of them can furnish appropriate and necessary care. I have seen this individual and evaluated him/her and his/her situation. I have also considered alternative modes of treatment. Available community resources have been investigated, and are not appropriate if hospitalization is recommended.

Signature of QMHP designated as a member of MHC Screening Team Date

**Name:**

PAGE 6B

**XI.** ***COMPLETE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)***

**ADMISSION CRITERIA**

**Level 1 Diagnostic Criteria (both required)**

[ ]  1. Axis I diagnosis that is psychiatric in nature and not solely due to MR/DD and/or substance abuse.

 ***If sole diagnosis of Substance abuse, refer youth to Prepaid Inpatient Health Plan (PIHP)***

[ ]  2. Less restrictive treatment is not considered to be adequate. Psychiatric Residential Treatment services can reasonably be

 expected to improve the youth’s condition or prevent further regression so that those services will no longer be needed.

**Level 2, Chronic Safety Concerns (at least one required) (if acute safety concerns, complete page 6A)**

[ ]  3. Suicide attempt, threats, gestures indicating potential danger to self.

[ ]  4. Homicidal threats or other assaultive behavior indicating potential danger to others.

[ ]  5. Self-care failure indicating an inability to care for own physical health and safety which creates a danger to own life.

**Level 3, Functional Impairment (at least one required)**

[ ]  6. Severely impaired social, familial, academic, or occupational functioning, which may include excessive use of substances.

[ ]  7. Severe maladaptive or destructive behaviors in school, home, or placement, which may include excessive use of substances.

[ ]  8. Extremely impulsive and demonstrates limited ability to delay gratification.

[ ]  9. Sexual acting-out that is harmful to self or others, and/or age inappropriate.

[ ]  10. History of running away which renders youth/others at risk.

**Level 4, Contingent: need for continual support (at least one required)**

[ ]  11. Need for medication evaluation or adjustment under close medical observation.

[ ]  12. Need for 24-hour structured environment due to inability to maintain treatment goals or stabilize in less

 intensive levels of care.

[ ]  13. Need for continuous secure setting with skilled observation and supervision.

**DISPOSITION/REIMBURSEMENT AUTHORIZATION**

[ ]  **(A.) Meets psychiatric residential treatment criteria; admission recommended.**

 **Admitted/transferred/referred to hospital**       **Admission Date**

**Risk factors associated with admission to PRTF:**

**Recommended Treatment Goals/Preliminary Discharge Plan:**

[ ]  **(B.) Alternative community services plan recommended in lieu of hospitalization, copy given to legally responsible individual.**

[ ]  **(C.) Does not meet inpatient criteria. Alternative community services plan recommended, copy given to legally responsible individual.**

**Comments:**

**CMHC Contact Person (name/center/phone #)**

I certify that:

[ ]  I have seen this individual and evaluated him/her and his/her situation including consulting with the legal guardian of the youth. I have reviewed the CBSP which indicates that local community resources have been identified and determined inadequate to meet the immediate treatment needs of the youth at this time.

[ ]  This is an Exception Screen; therefore the CBSP has not yet been completed. I have seen this individual and have evaluated him/her and his/her situation including consulting with the legal guardian of the youth. A short length of stay is authorized pending complete certification of need indicated by the CBSP.

Signature of QMHP/LMHP designated as a member of the screening team Date

PAGE 6C

 **Name:**

**XII. ALTERNATIVE COMMUNITY SERVICES PLAN**

**Consumer Strengths, Natural Supports, and Resources (friends, family, Peer Support, Consumer Run Organization):**

|  |  |
| --- | --- |
| 1.) |       |
| 2.) |       |
| 3.) |       |
| 4.) |       |

**Consumer Action Steps (Including Safety Plan):**

|  |  |
| --- | --- |
| 1.) |       |
| 2.) |       |
| 3.) |       |
| 4.) |       |

[ ] **Crisis Services (\*include provider address & phone number for appointments):**

 [ ] 24 Hour Crisis services available at #:       or address:

 [ ] Phone Welfare Check within 24 Hours at consumer number #:

[ ] Crisis Appointment (Specify type and provider appt within 24 hours of screen):

[ ] In Home Stabilization: [ ] Crisis Attendant Care [ ]  Peer Support [ ]  In Home Family Therapy

 [ ] Out of Home Crisis Stabilization:

 [ ] Other:

[ ] **Appointment:**

[ ] **Appointment:**

|  |
| --- |
| **DETAILS:**       |

[ ] **Outpatient Services (\*include provider address & phone number for appointments):**

[ ] Intake Assessment [ ] Psychotherapy [ ] Medication Services [ ] Private Practitioner

[ ] Case Management [ ] Attendant Care  [ ]  Psychosocial Rehab [ ] Family Therapy

[ ] Substance Evaluation [ ] MR/DD Services [ ] SED Waiver Services

[ ] Other (Community Resources):

[ ] **Appointment:**

[ ] **Appointment:**

[ ] **Appointment:**

|  |
| --- |
| **DETAILS:**       |

[ ] **Acute Care Services (Diversion from State Hospital):** **Facility**       **Date of Admission**

**Comments/Other (may include safety plan, consultations, other referrals etc.)**

 □ **Signature below indicates I have reviewed and received a copy of this plan**

Consumer and/or Legally Responsible Individual Date

QMHP/LMHP Date Collateral Date

PAGE 7

**STATEMENT FROM A QUALIFIED MENTAL HEALTH PROFESSIONAL**

**AUTHORIZING ADMISSION TO A KANSAS STATE PSYCHIATRIC HOSPITAL**

RE:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| (name of patient)  | (DOB) | (age) | (sex) |
|  |  |  |  |
|       |        |       |
| (patient’s address) |  | (city, state, zip) | (county residence, responsibility) |

Based upon my screening of the above named person, done by me in person and/or by review of this person’s records and of reports concerning this person, and being familiar with the resources and services which are available within this community, I find that the needs of this person for the services indicated below cannot be adequately met in this community, and I therefore authorize that the following service(s) be provided at a state psychiatric hospital.

**CHECK ONLY EACH TYPE OF SERVICE AUTHORIZED:**

1. [ ]  **VOLUNTARY** care and treatment (which this person has indicated to me that he/she wishes to be admitted for and which I believe he/she has the capacity to consent to (See KSA 59-2949(a)).
2. **INVOLUNTARY** care and treatment as specified below:

[ ]  EMERGENCY or TEMPORARY DETENTION AND TREATMENT pursuant to KSA 59-2954, or under the Court’s EX PARTE EMERGENCY CUSTODY ORDER (see KSA 59-2958), or under the Court’s TEMPORARY CUSTODY ORDER (see KSA 59-2959) if either are issued.

[ ]  MENTAL EVALUATION, including the examination(s) necessary to prepare the report to be submitted to the Court to assist in the trial of the issue of whether or not this person is a mentally ill person subject to involuntary commitment (see KSA 59-2961).

[ ]  INPATIENT CARE AND TREATMENT as may be ordered by the Court in any ORDER of CONTINUANCE AND REFERRAL (see KSA 59-2964) or ORDER FOR TREATMENT (see KSA 59-2966), or ORDER FOR CONTINUED TREATMENT (see KSA 59-2969(f)).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Date) (Signature of QMHP)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Telephone No.) (CMHC address)

[ ]  Original to be filed with the Court (if involuntary proceedings)

[ ]  Copy to       State Hospital

[ ]  Copy to       CMHC (if courtesy screen)

**EMERGENCY ROOM/HOSPITAL TRANSFERS: If the patient has been taken to any emergency room of any community hospital, or is currently admitted to any inpatient department at any community hospital, medical consultations must have been completed prior to any transfer of the patient to any state psychiatric hospital and the treating physician at the community hospital and the physician on duty at the state hospital must concur that the patient is medically stable and that the state hospital is capable of managing the patient’s physical condition (See 42U.S.C. Sec. 1395dd). List below (1) the name of the local treating/emergency room physician and (2) the name of the physician on duty at the state hospital who has agreed to accept the transfer:**

(1)       (2)

PAGE 8

**CERTIFICATE OF A PHYSICIAN, LICENSED PSYCHOLOGIST, OR A DESIGNATED**

**QUALIFIED MENTAL HEALTH PROFESSIONAL**

(to be attached to a Petition to Determine a Person to be a Mentally Ill Person Subject to Involuntary Commitment)

RE:

|  |
| --- |
|       |
| (name of patient) |
|  |  |
|       |       |
| (patient’s address) | (city, state, zip) |

I certify that:

 [ ] I am a [ ]  licensed physician; [ ] licensed psychologist; [x] qualified mental health professional designated by the head

 of a mental health center to make this certificate;

 [ ] I have on       (date) personally examined the above named patient and reviewed any available

 records, and on the basis thereof:

 [ ] It is my professional opinion that the patient is likely to be a mentally ill person subject to involuntary commitment for

 care and treatment as that term is defined in KSA 59-2946 (f), including that this patient:

 [ ]  is suffering from a mental disorder to the extent the person is in need of treatment;

[ ]  lacks the capacity to make an informed decision concerning treatment, despite conscientious efforts at

explanation or efforts to elicit a response from the patient showing an ability to engage in a rational decision-making process;

 [ ]  is likely to cause harm to self or others or substantial damage to property of another;

 [ ]  is not solely diagnosed with one of the following mental disorders: alcohol or chemical substance abuse;

anti-social personality disorder; mental retardation; organic personality syndrome; or an organic mental disorder.

 NOTE: all four of the above described conditions must be applicable to this person in order for the patient to meet

the legal definition of a mentally ill person subject to involuntary commitment.

 [ ] (OPTIONAL) For this reason, I recommend that the patient be detained and admitted to an appropriate inpatient

treatment facility for further observation and treatment pending Court proceedings.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (date) (Signature of physician, psychologist, QMHP)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (bus. Telephone no.) (name of facility, mental health center or clinic associated with)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (business address) (city, state, zip)

 [ ]  mental health center screening form attached

[ ]  other medical record or statement attached

[ ]  copy to

[ ]  copy to

PAGE 9

      STATE HOSPITAL

**APPLICATION FOR EMERGENCY ADMISSION (For Observation and Treatment)**

Purusant to KSA 59-2954 (b) or (c)

 Patient:

|  |  |  |  |
| --- | --- | --- | --- |
|   |  |  |  |
| (name) |  | (DOB) | (sex) |
|       |  |       |
| (home address) |  | (SSN) |
|       |  |       |
| (city, state, zip) |  | (county of residence) |
|       |  |       |
| (name of spouse or nearest relative) |  | (telephone no.) |
|       |  |       |
| (address, if different from the patient’s) |  | (telephone no.) |

I request admission of the above named person for emergency observation and treatment upon the following circumstances:

(1) [ ]  I am **a law enforcement officer** having custody of this person pursuant to the provisions of KSA 59-2953, and:

[ ]  I will file a petition seeking the involuntary commitment of this person with the District Court of       County, not later than the close of business on       (date), or;

[ ]  I have been informed by       that s/he will file such a petition. This individual may be contacted at:      .

(2) [ ]  I am **not** a law enforcement officer, but I am familiar with the circumstances of this patient immediately preceding this

 application, and I will file a petition seeking the involuntary commitment of the patient with the District Court of

       County, not later than the close of business on       (date).

(3) [ ]  I believe this patient to be a mentally ill person subject to involuntary commitment for care and treatment (as defined in

 KSA 59-2946(f) and is likely to cause harm to self or others if not immediately detained. In support thereof I state that:

(4) [ ]  The following criminal charges are known by me to be pending against this patient:

[ ]  None [ ]  It is unknown by me whether any charges are pending against this person.

(5) [ ]  Because this application is for admission to a state psychiatric hospital, the required statement from a qualified mental

 health professional is attached, having been obtained at the       Community Mental Health

 Center.

(6) [ ]  Other documentation, medical records or reports concerning this patient are attached.

(7) [ ]  Other documentation, medical records or reports concerning this patient may be found and consulted at:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(date) (signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(time) (printed name) (L.E.O. badge #)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (address)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(telephone no.) (city, state, zip)

PAGE 10