**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  Fair

Poor Lacking

**Orientation**

***Unable to assess***  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; 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