SHORT-TERM CRISIS STABILIZATION INTAKE AND ASSESSMENT REFERRAL FORM (NORTH STAR AND HEALY HOUSE)

For use by Northern Rivers Family of Services and member agencies

Please complete this intake assessment form to describe your recent mental health evaluation of the youth being referred, which is the basis on which the youth's admission is determined. **The face-to-face contact with the youth must have occurred within 48 hours of referral/admission. Please call 518.292.5499 to initiate the referral through our crisis line and then you'll be asked to fax this form in completion to 518.252.6445.**

A Identifying Information

Youth's name

Youth's date of birth

Parent's or guardian's name

Date of evaluation

Address

Phone number

Race

Ethnicity

Sexual orientation

Gender identity

Medicaid or insurance ID number (include sequence number)

Youth's social security number (required)

B Description of Crisis Situation/Rationale for Admission

Provide specific details about behaviors youth is exhibiting and insight into contributing factors. Also include statement on purpose of an admission:

C Brief Psychosocial Description

Developmental; family; prior mental health treatment; neglect, physical, or sexual abuse; substance abuse; physical health; schooling; religion; leisure time:

D Current Mental Status Exam

Describe appearance, attitude, and behavior:

Describe thought processes and content:

Describe perceptual disorder:

Describe mood and affect:

Describe any suicidal or homicidal ideation and behavior:

Describe cognitive functioning (orientation, memory, insight, and judgement):

E Psychiatric DSM-V Diagnosis

All mental and medical diagnoses (list all codes):

F Past and Present Risks

Suicidal or homicidal ideation or self-injurious behaviors :
Aggressive behavior or need for physical restraints/PRN medication (if yes, frequency and last need):
History of inpatient hospitalization and reason for admission (within last 6 months):
History of other high risk behaviors (fire-setting behaviors, sexualized behaviors, running away, substance abuse):

G Current Medication

Attach signed medication order that includes the following, which is required for admission:

MEDICATION	DOSAGE/TIMES	PRESCRIBING PHYSICIAN	PHYSICIAN'S PHONE NUMBER

H Current Providers

NAME	CONTACT INFORMATION	AGENCY (I.E. HEALTH HOMES, PREVENTION, CPS, CLINICIAN, ETC.)

I Additional Information

Can youth independently complete hygiene routines? (If no, please explain assistance needed.)

Is youth able to understand and follow policy and procedures?

J Description of Youth's Needs and Strengths/Goals for the Youth and Family

Assessment of youth's strengths and needs; goals for youth and family to be addressed:

K Discharge Plan

What skills need to be obtained in order to discharge, service needs, and where youth will reside after discharge:

Licensed Behavioral Health Provider signature

Date

Licensed Behavioral Health Provider name (print)

Phone number

Licensed Behavioral Health Provider email address