



Name (First MI Last):	Record #:	DOB:
------------------------------	------------------	-------------

Is person a MassHealth enrolled youth up to age 21 and in Intensive Case Coordination: No Yes **If Yes**
 If he/she was referred to Mobile Crisis Intervention by ICC indicate ICC team's assessment, interventions they tried during this episode, and ICC intervention and disposition recommendations?

FAMILY

Significant Family History and Functioning, including extended family, family/parental strengths and issues, etc.

Collaterals involved and/or Contacted				
Contact	Contact (Name)		Telephone	Date & Time
PCP				
Results:				
Clinician				
Results:				
Psychiatrist				
Results:				
DMH/DDS				
Results:				
DCF				
Results:				
School/ Residence				
Results:				
Guardian				
Indicate Type of Guardianship:				
Results:				
Family/ Sig Other				
Results:				
Other				
Results:				



Name (First MI Last):	Record #:	DOB:
-----------------------	-----------	------

Substance Use / Addictive Behavior History

Does person report a history of, or current, substance use or other addictive behavior concerns? No Yes; **If no, skip to MH Service History section. If yes, please complete and attach SU/Addictive Behavior History Addendum.**

Mental Health Service History

None Reported - If None Reported, skip to the Health Summary section

Mental Health Treatment: (Check all that apply) Residential/Supported Housing Assertive Community Treatment
 Outpatient Inpatient Day Treatment/Rehab/Clubhouse Other:

Type of Service	Dates of Service	Reason	Name of Provider/Agency:	Completed
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Previous or Current Diagnoses: Not known by person served /

Summary of Current Mental Health Functioning/Symptoms:

Current Medication Information (Include Non-Psych Meds/Prescription/ OTC/ Herbal) None Reported Unknown
 Roger's Guardianship: No Yes

Medication	Rationale/ Condition	Dosage / Route / Frequency	Reported Side-effects	Adherence WA = With Assistance	Prescriber
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	

Comments on Past Medications: (Include what medications have worked well previously, any adverse side effects, and/or which one(s) the person would like to avoid taking in the future.):



Name (First MI Last):		Record #:	DOB:
Trauma History (Describe in comments section each element checked)			
<input type="checkbox"/> No Self Reported History of Abuse/Violence		Comments: (Include single event versus sustained):	
Physical Abuse	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Domestic Violence/Abuse	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Elder Abuse	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Community Violence	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Physical Neglect	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Verbal/Emotional Abuse	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Sexual Abuse/Molestation	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Military Trauma	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Other Trauma	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Witness to Violence			
Witness to MH/SU issues of household members			
Current Involvement by: <input type="checkbox"/> None Reported <input type="checkbox"/> DCF <input type="checkbox"/> DPPC Comments:			
Additional Mandated Report Required?: <input type="checkbox"/> DCF <input type="checkbox"/> DPPC Comments:			



Name (First MI Last):	Record #:	DOB:
------------------------------	------------------	-------------

Mental Status Exam – (WNL = Within Normal Limits) (– If Checked, Risk Assessment is Required)**

Appearance: WNL Neat and appropriate Physically unkempt **Clothing:** WNL Disheveled
 Out of the ordinary

Eye Contact: WNL Avoidant Intense Intermittent

Build: WNL Thin Overweight Short Tall

Posture: WNL Slumped Rigid, tense Atypical

Body Movement: WNL Accelerated Slowed Peculiar Restless Agitated

Behavior: Relaxed Cooperative Uncooperative Overly compliant Withdrawn Sleepy Nervous / Anxious Restless
 Silly Avoidant / Guarded / Suspicious Preoccupied Demanding Controlling Unable to perceive pleasure Provocative
 Hyperactive Impulsive Agitated Angry Assaultive Aggressive Compulsive

Speech: WNL Mute Over-talkative Slowed Slurred Stammer Rapid Pressured
 Loud Soft Clear Repetitive

Emotional State-Mood: WNL Lack of feelings Blunted, unvarying Euphoric, elated Tranquil
 Anger Hostility Irritable Fear, apprehension Depressed, sadness Anxious

Emotional State-Affect: WNL Constricted Flat Inappropriate Changeable Full
 Panic attacks or symptoms Sleep disturbance Appetite disturbance

Facial Expression: WNL Anxiety, fear, apprehension Sadness, depression Anger, hostility, irritability
 Expressionless Unvarying Inappropriate Elated

Perception: WNL Illusions Depersonalization De-realization Re-experiencing
Hallucinations - Auditory Visual Olfactory Gustatory Tactile Command**

Thought Content: WNL
Delusions - None reported Grandiose Persecutory Somatic Illogical Chaotic Religious
Other Content - Preoccupied Obsessional Guarded Phobic Suspicious Guilty
 Thought broadcasting Thought insertion Ideas of reference
Self Abuse Thoughts- None reported Cutting** Burning** Other self mutilation**
Suicidal Thoughts - None reported Passive SI** Intent** Plan** Means**
Aggressive Thoughts - None reported Intent** Plan** Means**

Thought Process WNL Incoherent Circumstantial Decreased thought flow
 Blocked Flight of ideas Loose Racing Increased thought flow Concrete Tangential

Intellectual Functioning WNL Lessened fund of common knowledge Short attention span
 Impaired concentration Impaired calculation ability
Intelligence Estimate - MR Borderline Average Above average No formal testing

Orientation: WNL **Disoriented to:** Person Time Place

Memory: WNL **Impaired:** Immediate recall Recent memory Remote memory

Insight: WNL Difficulty acknowledging presence of psychological problems
 Mostly blames other for problems Thinks he/she has no problems

Judgment: WNL **Impaired Ability to Make Reasonable Decisions:** Some Severe**

Past Attempts to Harm Self or Others: None Reported Self** Others**
Comment:

Comments:



Name (First MI Last):	Record #:	DOB:
------------------------------	------------------	-------------

Risk Assessment

Assess each risk factor and rate from 'No Risk' to 'High' Risk and check each row accordingly

Risk Factors	<input type="checkbox"/>	No Risk	<input type="checkbox"/>	Low	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	High
Plan to Harm Self	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Plan	<input type="checkbox"/>	Vague Plan	<input type="checkbox"/>	Specific Plan
Means Accessibility	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Poor Access	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Possesses
Lethality Of Means	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Low Lethality	<input type="checkbox"/>	Potentially Lethal	<input type="checkbox"/>	Lethal
Suicidal History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Gesture(s)	<input type="checkbox"/>	Attempt(s)
Lethality Of Attempts	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Non-Lethal	<input type="checkbox"/>	Injurious	<input type="checkbox"/>	Potentially Lethal
Last Attempt	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Family History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	Death(s) By Suicide
Plan To Harm Others	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Plan	<input type="checkbox"/>	Vague Plan	<input type="checkbox"/>	Specific Plan
Means Accessibility	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Poor Access	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Possesses
Lethality Of Means	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Low Lethality	<input type="checkbox"/>	Potentially Lethal	<input type="checkbox"/>	Lethal
Assault History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Single Assault	<input type="checkbox"/>	Multiple Assaults
Lethality Of Assaults	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minor Injuries	<input type="checkbox"/>	Moderate Injuries	<input type="checkbox"/>	Severe Injuries
Last Assault	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Family History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	None	<input type="checkbox"/>	Periodic Violence	<input type="checkbox"/>	Persistent Violence
Arrest Record	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	None	<input type="checkbox"/>	Single Arrest	<input type="checkbox"/>	Multiple Arrests
Physical Abuse Hx	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minimal Abuse	<input type="checkbox"/>	Moderate Abuse	<input type="checkbox"/>	Severe Abuse
Sexual Abuse Hx	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Abuse Reported	<input type="checkbox"/>	Abuse Reported	<input type="checkbox"/>	Severe Abuse
Substance Abuse	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Social Use	<input type="checkbox"/>	AoD Abuse Hx Not Under Influence	<input type="checkbox"/>	AoD Dependent &/Or Under The Influence
Sexualized Behavior	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Runaway Risk	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Delinquent Behavior	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minimal	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Fire Setting	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Gambling	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Bullying	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Other Risk Behavior	<input type="checkbox"/>							
Mental Status								
Hallucinations	<input type="checkbox"/>	None reported	<input type="checkbox"/>	Periodic or non-intrusive	<input type="checkbox"/>	Troubling Hallucinations	<input type="checkbox"/>	Command Hallucinations
Judgment and Reality Testing	<input type="checkbox"/>	Intact and functional	<input type="checkbox"/>	Predominantly intact and functional	<input type="checkbox"/>	Periodically impaired	<input type="checkbox"/>	Grossly impaired
Orientation	<input type="checkbox"/>	Hopeful/Immediate and distant future oriented	<input type="checkbox"/>	Predominantly hopeful and future oriented	<input type="checkbox"/>	Minimal hope and sense of efficacy	<input type="checkbox"/>	Hopeless/helpless
Interpersonal interactions	<input type="checkbox"/>	Fully interactive	<input type="checkbox"/>	Intermittent contact with others	<input type="checkbox"/>	Minimal contact with others	<input type="checkbox"/>	Isolated
Impulsivity	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Stress	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minimal	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Loss	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Physical Condition	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Financial Stress	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Living Arrangements	<input type="checkbox"/>	Safe	<input type="checkbox"/>	With Others	<input type="checkbox"/>	Access To Others	<input type="checkbox"/>	Alone/Isolated
Support From Significant Others	<input type="checkbox"/>	Positive/Helpful	<input type="checkbox"/>	Present/Helpful	<input type="checkbox"/>	Accessible/Somewhat Helpful	<input type="checkbox"/>	Unable/Unwilling To Help
Male Age Suicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	35-49	<input type="checkbox"/>	13-34	<input type="checkbox"/>	50+
Homicide	<input type="checkbox"/>	1-8	<input type="checkbox"/>	9-12/60+	<input type="checkbox"/>	13-16/30-60	<input type="checkbox"/>	17-30
Female Age Suicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	39-59	<input type="checkbox"/>	13-38	<input type="checkbox"/>	60+
Homicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	45+	<input type="checkbox"/>	13- 16/26-44	<input type="checkbox"/>	17-25



Name (First MI Last):	Record #:	DOB:
-----------------------	-----------	------

Risk Assessment - Continued

Overall Risk Level:	None: <input type="checkbox"/> Self <input type="checkbox"/> Other	Low: <input type="checkbox"/> Self <input type="checkbox"/> Other	Moderate: <input type="checkbox"/> Self <input type="checkbox"/> Other	High: <input type="checkbox"/> Self <input type="checkbox"/> Other
---------------------	--	---	--	--

Comments:

Safety/risk issues for the parent/guardian/caregiver:

Assessed Needs Checklist Including Functional Domains

✓	Check All Current Problem Areas	As Evidenced By:	Person Served Desires Change Now?:
<i>Activities of Daily Living</i>			
<input type="checkbox"/>	Activities of Daily Living		<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Addictive Behaviors</i>			
<input type="checkbox"/>	Substance Use/Addiction:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other Addictive Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Behavior Management</i>			
<input type="checkbox"/>	Anger/Aggression:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Antisocial Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Impulsivity:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Lack of Assertiveness:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Oppositional Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Family and Social Support</i>			
<input type="checkbox"/>	Communication Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Community Integration:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Dependency Issues:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Family Education: (Family education must be directed to the exclusive well being of the person served)		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Family Relationships:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Peer Support:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Personal Support Network:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Recreation/Leisure Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Social/Interpersonal Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Home		<input type="checkbox"/> Yes <input type="checkbox"/> No



Name (First MI Last):		Record #:	DOB:
<input type="checkbox"/>	School		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health/Illness Management			
<input type="checkbox"/>	Anxiety:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Coping/ Symptom Management Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Cognitive Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Compulsive Behavior:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Depression/Sadness:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Dissociation:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Disturbed Reality (Psychosis):		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Gender Identity Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Grief/Bereavement:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Hyperactivity/Hypomania:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Mood Swings:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Obsessions:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Somatic Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Stress Management:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Trauma:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Risk/Safety			
<input type="checkbox"/>	High Risk Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Safety/Self-Preservation Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			
<input type="checkbox"/>	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No



Name (First MI Last):	Record #:	DOB:
------------------------------	------------------	-------------

Person's Served Strengths/Abilities/Resiliency (Skills, talents, interests, aspirations, protective factors)	
Personal Qualities:	
Daily Living Situation:	
Financial:	
Employment/Education:	
School, Family and Social Supports:	
Health:	
Leisure/Recreational:	
Spirituality/Culture/Religion:	
Parental:	
Other:	

Parent/guardian/caregiver strengths and resources and how they impact their ability to care for the youth's behavioral health needs:

Natural supports, community resources and professionals that can assist in stabilizing the current situation and offer ongoing support to the youth and parent/guardian/caregivers:

Person Served/Family/Guardian Expression of Service Preferences:

Behavioral Health Clinical and Rehabilitative Service Preferences:

Environmental Support Preferences:

Intervention and Stabilization:
Therapeutic Interventions Delivered, including solution-focused crisis counseling and brief interventions that address behavior and safety:

Person's and family's Response to Interventions:



Name (First MI Last):	Record #:	DOB:
------------------------------	------------------	-------------

Stabilization Activities: N/A (If N/A Explain):

Clinical Formulation – Interpretive Summary

This Clinical Formulation is Based Upon Information Provided By (Check all that apply):

- | | | | | | |
|--|---|---|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> Person Served | <input type="checkbox"/> Parent(s) | <input type="checkbox"/> Guardian(s) | <input type="checkbox"/> Family/Friend(s) | <input type="checkbox"/> Physician | <input type="checkbox"/> Records |
| <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Service Provider | <input type="checkbox"/> School Personnel | <input type="checkbox"/> Other: | | |

Interpretive Summary: What in your clinical judgment are the issue(s), the factors that led to the issues, and your plan to address the issues? This section should reflect the person's status, and your plan, after the ESP has provided crisis intervention and stabilization activities as reflected in the previous section.

Diagnosis: DSM Codes (or successor) ICD Codes (or successor)

Check Primary	Axis	Code	Narrative Description
<input type="checkbox"/>	Axis I		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>	Axis II		
<input type="checkbox"/>			
<input type="checkbox"/>	Axis III		
<input type="checkbox"/>	Axis IV		
<input type="checkbox"/>	Axis V	Current GAF:	Highest GAF in Past Year (if known):

Further Evaluations Needed:

- | | | | | | |
|---|--------------------------------------|--|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> None Indicated | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Psychological | <input type="checkbox"/> Neurological | <input type="checkbox"/> Medical | <input type="checkbox"/> Educational |
| <input type="checkbox"/> Vocational | <input type="checkbox"/> Visual | <input type="checkbox"/> Auditory | <input type="checkbox"/> Nutritional | <input type="checkbox"/> SU Assessment | |
| <input type="checkbox"/> Other: | | | | | |

Was Outcomes tool administered? Yes No If Yes, specify:



Name (First MI Last):		Record #:	DOB:	
Prioritized Assessed Needs to be addressed at the next Level of Care as Evidenced by: A-Active, PR-Person Decline, D-Deferred, R-Referred Out (If deferred, please provide rationale)				
	A	PD*	D*	R
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deferred Rationale(s):				

Disposition Details:

Collateral Details:

Information Gathered from: Person served Family/guardian Hospital Staff Reports Therapist Psychiatrist
 Residential Staff PCP Friend Other:

- Personal Safety Check By:
- Medical Clearance Needed? No Yes. If Yes, completed by:
- Psychiatric Consult with
- Urgent psychopharmacology provided by
- Section 12 Authorization By:

Current Safety Assessment Verbal Contract Written Contract N/A (explain)

- Able to contract for safety in the community
- Able to contract for safety in a supportive environment only
- Unable to contract for safety
- Other:

Level of Care/Indicated Services Recommendation (check all that apply):

- No services needed at this time
- Refused all recommendations and services against medical/clinical advice
- Medical inpatient admission (non observation)
- Other:
- Outpatient Referral Outpatient Facility Utilized:
- Home based outreach services. Services Utilized: FST CSP Other
- ICC Referral
- Diversion Services Facility Utilized:
- Service Utilized:**
 - 24-72 hour medical or psychiatric observation admission
 - Community Crisis Stabilization Program
 - DMH/DDS Respite Bed (with approval of DMH / DDS Case Manager)
 - CBAT/ICBAT
 - Substance abuse program
 - Detox Outpatient Rehab/Residential DDRT
 - Partial Hospitalization Day Treatment
 - Peer or family Support/self help/family or consumer operated program
 - Specializing by:
- Psychiatric Inpatient Referral Voluntary involuntary Facility:

