MENTAL HEALTH SCREENING FORM

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

QMHP/LMHP **Location of Interview**

Screen Date **Screen Start Time** **AM/PM** **Screen Decision Time** **AM/PM**

Screening CMHC/LMHP

Courtesy Screen ☐ No ☐ Yes CMHC **Staff** **Date/Time**

☐ 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 ☐ DCF_____
☐ 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)**:** _____

_____

_____

_____

Revised September 2012

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):** _____

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 ☐ Impaired 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 exploitiveness
☐ 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:_____

_____

_____

_____

_____

_____

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.***

Name: _____

IX. *COMPLETE FOR <u>MEDICAID INPATIENT PSYCHIATRIC</u>, <u>KVC PRAIRIE RIDGE STAR</u>, and <u>KVC WHEATLAND SCREENS</u>*

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

Revised September 2012

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**

☐ Recommended **VOLUNTARY** admission to _____State Hospital.

☐ Recommended **INVOLUNTARY** admission to _____State Hospital 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.

☐ 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.**

☐ 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 _____

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

Revised September 2012

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

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)

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:

A. ☐ **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)).

B. **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) _____

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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 _____

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_____ 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)

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)