DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
1901 North DuPont Highway, New Castle, Delaware 19720
Eligibility & Enrollment Unit 302.255.9458 Crisis Intervention Services 800.652.2929

INITIAL BEHAVIORAL HEALTH ASSESSMENT

Fax copy of completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.255.4416 or outside business hours, to 302.255.9952

Instructions: *This form is to be completed, signed, and dated for all clients who are being referred for psychiatric services.*

Presentation at ED ☐ Self ☐ Family/Friend ☐ Police ☐ Provider ☐ Other ☐ N/A ☐ CIS

Referral Source/Relationship _____ Date/Time of Referral _____

☐ On site OR ☐ Walk In AND ☐ Scheduled OR ☐ Unscheduled

Assessment Began _____ (Date (MM/DD/YYYY)) and _____ (Time (00:00)) a.m. p.m. Ended _____ (Date (MM/DD/YYYY)) and _____ (Time (00:00)) a.m. p.m.

Name of Client _____ ☐ Male ☐ Female

_____ (Street Address) _____ (City) _____ (Zip) (_____) _____-_____ (PHONE)

State/County of Residence ☐ Delaware and County: ☐ New Castle ☐ Kent ☐ Sussex ☐ Homeless ☐ Other State _____

Date of Birth ☐☐ (m m) ☐☐ (d d) ☐☐ (y y) Social Sec # ☐☐☐ ☐☐ ☐☐☐☐

Employed ☐ YES ☐ NO ☐ Unknown Occupation _____ Veteran Yes ☐ No ☐
Combat? Yes ☐ No ☐

Race/Ethnicity ☐ African American ☐ Asian American ☐ Caucasian ☐ Native Amerian ☐ Other _____ Latin/Hispanic ☐ Yes ☐ No

Language ☐ English ☐ Spanish ☐ Creole ☐ Chinese ☐ Other _____ Limited English Proficiency ☐ Yes ☐ No

☐ Deaf/Hard of Hearing with ☐ American Sign Language Interpreter Needed ☐ Yes ☐ No

☐ Deaf/Hard of Hearing (does not communicate using ASL)

Medicaid # ☐☐☐☐☐☐☐☐☐☐ INSURANCE ☐ Medicare ☐ NO INSURANCE

☐ Aetna ☐ BC/BS ☐ Carve-out ☐ Cigna ☐ Coventry ☐ Diamond State ☐ DPCI ☐ UHC ☐ Tri-Care

☐ Other Insurer _____

DSAMH MH Provider Name: _____ or ☐ NONE

☐ ACT ☐ ICM ☐ CRISP Location/Team _____

☐ Wilmington MHC ☐ Dover MHC ☐ Georgetown MHC ☐ Other or Group Home _____

Provider notified? ☐ Yes ☐ No ☐ N/A Name/Phone# _____

Probation/Legal History/TASC ☐ YES ☐ NO ☐ Unknown (If YES, detail on separate sheet if relevant)

Name of Client_____ DOB _____

Presenting Issues (History of presenting problem, precipitating/participating factors and current systems):

_____

_____

_____

_____

_____

Current Functioning/Behavior Changes related to presenting problem (Note/describe any changes and/or difficulties present in the following areas):

Eating ☐ same ☐ changed (how) _____

Weight Gain/Loss ☐ same ☐ changed (how) _____

Sleeping ____hours/night ☐ same ☐ changed (how) _____

Personal Care ☐ same ☐ changed (how) _____

Energy ☐ same ☐ changed (how) _____

Concentration ☐ same ☐ changed (how) _____

Working / School ☐ same ☐ changed (how) _____

Family/children/Social ☐ same ☐ changed (how) _____

Problems associated with addictive behavior (gambling/shopping/Internet/sex) ☐ YES ☐ NO ☐ Unknown

Other functional issues: _____

Marital Status ☐ Single ☐ Married/Civil Union ☐ Separated ☐ Divorced ☐ Widowed ☐ Living With_____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Asexual ☐ Undisclosed

Recent Stressors: ☐ Relationship ☐ Family ☐ Job ☐ Housing ☐ Financial ☐ Legal ☐ Other _____

Health Issues: ☐ IDDM ☐ NIDDM ☐ Hypertension ☐ Cardiac ☐ HIV Status ☐ Hep C ☐ Other _____

Special Needs: ☐ Wheelchair ☐ Oxygen ☐ Walker ☐ Crutches ☐ Cane

☐ Other _____

Medical History/Treatment/Pertinent injuries: (diagnosis/describe) _____

_____

Medical Provider: _____

Behavioral Health History/Treatment

Substance Use History/Treatment

Is there a family history of substance use issues? ☐ YES ☐ NO ☐ Unknown

Does the person currently use mind-altering substances (drugs, alcohol, marijuana, etc.) ☐ YES ☐ NO ☐ Unknown

If yes, what substances

☐ Opiates ☐ Cocaine ☐ Cannabis ☐ Benzos ☐ Amphetamines ☐ Alcohol ☐ Ecstasy ☐ Bath Salts ☐ PCP

When last used:_____

☐ N/A _____ BAL/Breathalyzer UDS Other: _____

Any past or current treatment for substance use (describe; include dates, include ER meds, and if restraints used):

_____

_____

Mental Health History/Treatment

Is there a family history of mental health issues? ☐ YES ☐ NO ☐ Unknown

(diagnosis/describe) _____

Is there a family history of suicide attempt(s) or completion(s)? ☐ YES ☐ NO ☐ Unknown

(describe)_____

Name of Client_____ **DOB** _____

Any Past Hospitalizations (date(s), descriptions) _____

Current Treating Psychiatrist ☐ **YES** ☐ **NO** **Name/Date last seen** _____

Anhedonia ☐ **Yes** ☐ **No** **Hopelessness** ☐ **Yes** ☐ **No** **Self-mutilation** ☐ **Yes** ☐ **No** **Judgement intact** ☐ **Yes** ☐ **No**

Mental Status (Circle all that apply):

Appearance	Neat	Well Groomed	Disheveled	Dirty	Drowsy	Intoxicated	Casual	
Eye Contact	Adequate	Intense	Staring	Avoidant	Guarded	Poor	Other_____	
Speech	Normal	Soft	Loud	Slowed	Slurred	Pressured	Repetitive	
Interaction	Pleasant	Cooperative	Angry	Guarded	Suspicious	Apathetic	Aloof	Passive
Motor Activity	Appropriate	Restless	Hyperactive	Repetitive	Agitated			
Affect	Full Range	Flat	Blunted	Labile	Constricted	Tearful	Inappropriate	
Mood	Calm	Anxious	Depressed	Manic	Hostile	Sad	Euphoric	
Thought Process	Coherent	Goal Directed	Blocking	Loose Associations	Tangential	Word Salad		
Thought Content	Coherent	Suicidal	Homicidal	Hallucinations:	Auditory	Visual	Olfactory	Tactile
	Grandiose	Delusional	Persecutory	Somatic	Jealousy	Religious	Broadcasting	
Orientation	Oriented	Person	Place	Time	Disoriented			

Risk Assessment (Note/describe any difficulties present):

Suicidal: NO ☐ **Denies current thoughts of self-directed harm and is future oriented** **OR** Passive Thoughts ☐ **YES** ☐ **NO**

Active Recurrent Thoughts ☐ **YES** ☐ **NO** Making Threats ☐ **YES** ☐ **NO** Left Note ☐ **YES** ☐ **NO**

Actionable Plan ☐ **YES** ☐ **NO** Available Weapons/Means ☐ **YES** ☐ **NO** Currently Attempted ☐ **YES** ☐ **NO**

Command Hallucinations ☐ **Yes** ☐ **No** History of Suicide Attempts ☐ **YES** ☐ **NO**

Details (when/how/what prevented or stopped attempt?)_____

_____

Homicidal Thoughts/Violence: NO ☐ **Denies current thoughts of other-directed harm. OR** Passive Thoughts ☐ **YES** ☐ **NO**

Active Recurrent Thoughts ☐ **YES** ☐ **NO** Making Threats ☐ **YES** ☐ **NO** History of Violence ☐ **YES** ☐ **NO**

Actionable Plan ☐ **YES** ☐ **NO** Access to weapons/means ☐ **YES** ☐ **NO**

Command Hallucinations ☐ **YES** ☐ **NO** **Identified target/individual?** Duty to Warn? ☐ **YES** ☐ **NO**_____

_____

Current/history of Violent Behavior ☐ **NO/Denies** ☐ **YES** Details/thoughts/plans_____

_____

_____

_____

Name of Client_____ **DOB** _____

Comments on Risk/Safety Plan: _____

Trauma History: _____

Diagnostic Impression: _____

Current Medications:

Prescriber: PCP ☐ Specialist ☐ Psychiatrist ☐

_____
Drug/Dosage

_____ ☐ ☐ ☐
Drug/Dosage

_____ ☐ ☐ ☐
Drug/Dosage

Disposition/Plan:

☐ Home with Referrals_____

☐ Home with WBC/WBV If Yes Start Date_____End Date_____ Was authorization to leave message obtained ? ☐ Yes ☐ No

☐ Outpatient Treatment Referrals_____ ☐ Crisis Bed

Hospitalization ☐ Voluntary ☐ Involuntary _____

Other/Describe_____

☐ Referral Sheet Signed? ☐ Yes ☐ No If No Why not?_____

Release of Information Signed? ☐ Yes ☐ No If Yes For Whom/Ageny_____

Del. Administrative Code, Title 16, Reg 6002, Sec. 6.1 Conflict of Interest Statement: The intent of the law is to ensure that no person is detained for any reason other than experiencing symptoms associated with a mental condition that may result in danger to self or others, and that any conflicts of interest as set forth in 16 Del.C. §5122 are disclosed on the DSAMH Crisis Intervention Assessment Tool and 24-hour Emergency Admission form filed with DSAMH within 24 hours of signature of the detention order. DSAMH will collect and monitor all assessments, detentions and non-detentions performed by credentialed mental health screeners, whether a conflict of interest is disclosed or not, for purposes of ensuring that the intent of this law is met and that admissions are appropriate.

Conflict of Interest Disclosure Statement:

☐ No conflicts ☐ Yes, as follows: _____

_____

By my signature, I certify that I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder.

_____ _____ _____
Signature Date and Time

_____ _____
Print Name/Title/Unit Telephone