



Referral Date: Month Day Year

DBHDD Region: Click on Region to select

Demographic Information		
Name (Firstname Lastname):	Legal Name (if different):	Ethnicity Click to Select Ethnic Background
DOB:	Age:	Marital Status: Click on Status to select
SSN:	Gender: Click to select	Disability Category: Click on Category to choose
Address:		
Home Phone:	Work:	Cell:
Legal Guardian: Does individual have a legal guardian?	Legal Guardian Name:	Legal Guardian Phone:
Emergency Contact:	Emergency Contact Phone:	Emergency Contact Phone:

Financial Information	
Insurance Type: Click to choose type of insurance	Primary Insurance:
Subscriber Name:	Relationship to Consumer: Click to choose relationship
Policy Number:	Group Number:

Dispatch Information	
GCAL Dispatch Date & Time: Month Day Year Hour Minute Select	MCRS Accept Date & Time: Month Day Year Hour Minute Select
Arrival Date & Time: Month Day Year Hour Minute Select	Crisis Location: Click to select Crisis Location
Crisis County: Click to select Crisis County	Describe:
Assessment Location: Click to select Assessment Location	Describe:
☐ Made Face-to-Face Contact ☐ Unable to Make Face-to-Face Contact:	☐ Unable to Make Face-to-Face Contact: ☐ Call Cancelled Rationale

Presenting Problem (Include Consumer's Self Report, Clinical Observations, and Collateral Information):		
Check All That Apply:		
☐ Elopement	☐ Non-Compliant	☐ Placing Self in Harmful Situation
☐ Suicide Attempt	☐ Physical Aggression toward Family	☐ Suspected Drug/Alcohol Misuse
☐ Suicidal Ideation	☐ Physical Aggression toward Others	☐ Verbal threats to harm others
☐ Depression	☐ Self-Injurious Behavior	☐ Verbal Aggression
☐ Food/Drink Refusal	☐ Property Destruction	☐ Active Psychosis
Comments:		

Complete this section (Pages 2 and 3) for all individuals under the age of 18 (For adults proceed to next section, starting on Page 4)			
School Information (complete and check all that apply):			
Grade:		Year at Current School:	
Any Grade Repeated: ☐ Yes ☐ No		List Grade(s) repeated:	
Identified Learning Problems (check all that apply):			
☐ Behavioral	☐ Speech-language	☐ Gross motor skills	
☐ Emotional	☐ Reading	☐ Cognitive delays	
☐ Math	☐ Fine motor skills	☐ Other (list below)	
Comments:			
Special Education (IEP) : ☐ Yes ☐ No			
Comments:			
Is there any significant changes in school performance or peer relationships: ☐ Yes ☐ No			
Explain:			
School Behaviors (check all that apply):			
☐ Enjoys school	☐ Inattention	☐ School refusal	
☐ Follows rules	☐ Withdrawn	☐ Disruptive behaviors	
☐ Passing	☐ Hyperactivity	☐ Truancy	
☐ Separation problems	☐ Oppositional	☐ Aggression	
☐ Failing	☐ Irregular attendance	☐ Other (list below)	
Comments:			
History of Suspension or Expulsion: ☐ Yes ☐ No			
Comments:			
Psychosocial Risk Assessment (Check and use "Comments" to describe positive findings) :			
Failure to thrive:	☐ Not Applicable	☐ Current	☐ Past
Child abuse/sexual abuse/neglect:	☐ Not Applicable	☐ Current	☐ Past
Exposure to domestic violence:	☐ Not Applicable	☐ Current	☐ Past
History of out-of-home placement:	☐ Not Applicable	☐ Current	☐ Past
At risk of out-of-home placement:	☐ Not Applicable	☐ Current	☐ Past
Homeless:	☐ Not Applicable	☐ Current	☐ Past
Developmental disabilities in caregivers:	☐ Not Applicable	☐ Current	☐ Past
Family history of mental illness:	☐ Not Applicable	☐ Current	☐ Past
Impulsive/acting out:	☐ Not Applicable	☐ Current	☐ Past
Comments:			
History of Department of Family and Children's Services (DFCS) involvement (Child Protective Services/Foster Care/Kinship Care): ☐ Yes ☐ No			
Comments:			

History of Department of Juvenile Justice involvement (If Yes, provide probation officers name and contact info): ☐ Yes ☐ No		
Comments:		
Family Composition (guardianship/custody issues, to include parent or guardian's willingness to participate in services. Provide their strengths/needs):		
Comments:		
Developmental History		
History of Low Birth Weight: ☐ Yes ☐ No		
Comments:		
History of Pre-Maturity or Birth Complications: ☐ Yes ☐ No		
Comments:		
History of prenatal exposure to alcohol, tobacco or other substances: ☐ Yes ☐ No		
Comments:		
Developmental Milestones: ☐ Yes ☐ No		
☐ Met developmental milestones on time	☐ Minor delays	☐ Major delays (walked, talked, etc.)
Comments:		
Enuresis (mark all that apply):		
☐ None	☐ Current	☐ Past ☐ Toilet training in process ☐ Not Applicable
Comments:		
Encopresis (mark all that apply):		
☐ None	☐ Current	☐ Past ☐ Toilet training in process ☐ Not Applicable
Comments:		
Intellectual Disability: ☐ Yes ☐ No		
If "Yes", is the disability :		
☐ Mild	☐ Moderate	☐ Severe
Comments:		
Note any Significant Developmental History Not Mentioned Above:		

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Past month	
Ask questions that are bolded and <u>underlined</u> .		YES	NO
Ask Questions 1 and 2			
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		☐	☐
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, " <i>I've thought about killing myself</i> " without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>		☐	☐
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. " <i>I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.</i> " <u>Have you been thinking about how you might kill yourself?</u>		☐	☐
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to " <i>I have the thoughts but I definitely will not do anything about them.</i> " <u>Have you had these thoughts and had some intention of acting on them?</u>		☐	☐
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		☐	☐
6) Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		☐	☐
6a) If YES, ask: <u>How long ago did you do any of these?</u> ☐ Over a year ago? ☐ Between three months and a year ago? ☐ Within the last three months?		☐	☐

Risk Assessment	
Suicidal Ideation: ☐ None ☐ Passive ☐ Active	If Suicidal Ideation Present: ☐ Plan ☐ Means ☐ Intent
Describe:	
Homicidal Ideation: ☐ None ☐ Passive ☐ Active	If Homicidal Ideation Present: ☐ Plan ☐ Means ☐ Intent
Describe:	
Aggressive Thoughts/Behaviors: ☐ Yes ☐ No	
Describe:	
Brief Mental Status	
General Appearance:	Body Type: Report Individual's Body Type: Weight: Select Appropriate Weight Rating: Hygiene: Select Appropriate Hygiene Rating: Eye Contact: Report Individual's Eye Contact: Comments:
Motor:	Muscular/Skeletal: Report Musculoskeletal Activity: Gait: Assess Individual's Gait: Movement: Assess Individual's Movement: Comments:
Regulation:	Activity Level: Assess Individual's Activity Level: Alertness: Assess Individual's Alertness: Affect: Assess Individual's Affect: Mood: Assess Individual's Mood: Oriented to: ☐ Person ☐ Place ☐ Time ☐ Situation Comments:
Cognition/Thought Processes	Hallucinations: Report Hallucinations That Individual Experiences: Delusions: Report Any Delusions That Individual Has: Thought Processes: Assess Individual's Thought Processes: Associations: Assess Associations: Insight: Assess Individual's Insight: Judgment: Assess Individual's Judgement: Comments:
Communication:	Speech: Assess Individual's Speech: Receptive Language: Assess Individual's Receptive Language: Expressive Language: Assess Individual's Expressive Language: Comments:
Change In Biological Functioning	Sleep Patterns: Assess Individual's Sleep Patterns: Eating Patterns: Assess Individual's Eating Patterns: Comments:

Unusual Behaviors	☐ Not applicable ☐ Head banging ☐ Hair pulling ☐ Compulsions ☐ Spinning/twirling ☐ Other: ☐ Sexual acting out ☐ Hand flapping ☐ Traumatic reenactments ☐ Repetitive, bizarre verbalizations Comments:
Interpersonal Behaviors:	Engagement with Examiner: Assess Individual's Engagement With Examiner: Engagement with Caregivers or Family: Assess Individual's Engagement With Caregivers or Family: Self Perceptions: Assess Individual's Self-Perception: Comments:
Autism Spectrum Disorder:	☐ Yes ☐ No ☐ Unknown Note: If yes address specific deficit domain, include social impairment, language/communication impairment, and repetitive/restrictive behaviors. Comments:

Substance Abuse			
Current use of:	Alcohol ☐ Yes ☐ No	Drugs ☐ Yes ☐ No	If yes to any complete complete the section below:
Past use of:	Alcohol ☐ Yes ☐ No	Drugs ☐ Yes ☐ No	
Substance	Age First Used	Last Use	Pattern of Use (amount, frequency, duration, route)
History of 12 – Step Attendance? ☐ Yes ☐ No If yes, Time period of attendance:			
History of Withdrawal Symptoms? Check box(s)			
☐ None Reported	☐ AM Alcohol/Drug Use	☐ Agitation	☐ Anxiety
☐ Insomnia	☐ Shakes	☐ Nausea	☐ Violence
		☐ DT's	☐ Depression
		☐ Seizures	☐ Excessive Sweating
		☐ Hallucinations	☐ Shortness of Breath
		☐ High Blood Pressure	☐ Vomiting
		☐ Suicidality	☐ Other:

Supports		
Supportive Person(s):	Phone:	
Click to choose current living arrangements		
Current Provider(s)		
Provider:	Phone:	Services Received:
Select DD Waiver or Planning List Status		
b1-YŠ 2f {dZLJ2W / 22Ry1-02y !Šy0ē: Select Support Coordination Agency		
{ / !Šy0ē 2f t[! b20t1ŠR 2f /W0A0 ☐ Yes ☐ N/A ☐ No (Give Reason in Text Box Below)		

Current Medications					
Allergies:					
Consumer Reports Compliance with Medications: Click to choose consumer reported compliance with medications					
☐ See Attached List					
MEDICATION NAME	DOSE	FREQUENCY	INDICATION	LAST DOSE TAKEN	PRESCRIBING PHYSICIAN

History	
Treatment History	
Previous MCRS Involvement: ☐ Yes ☐ No	Response to Previous to MCRS:
Previous MH/SA Diagnosis: ☐ Yes ☐ No Describe:	Intellectual Disability Diagnosis: ☐ Yes ☐ No Describe:
History of Suicidal Thoughts &/or Attempts: ☐ Yes ☐ No Describe:	History of Homicidal Thoughts &/or Aggression: ☐ Yes ☐ No Describe:
Previous Inpatient Treatment Provider(s)	Dates
Previous Outpatient Treatment Provider(s)	Dates
Abuse History	
☐ None ☐ Physical ☐ Sexual ☐ Emotional Describe:	
Legal History	
☐ None ☐ Pending Charges ☐ Current Parole/Probation ☐ Prior Offenses Describe:	
Family History of Mental Illness/Substance Abuse	
Describe:	
Family History of Suicide	
Describe:	

ADA Target Population Group: (check all that apply)

☐ Does not appear to meet target criteria	☐ Chronically homeless
☐ Currently in/pending discharge from psychiatric inpatient facility	☐ Frequent readmit to psychiatric inpatient facility
☐ Frequently seen in ER for behavioral health needs	☐ Pending/recent release from jail/prison

Diagnostic Impression

C2W 55t Ly0fzRS uSfS0f-y0 lyf2WYI-0i2y/200f-iySR Fw2Y /L{ wS0iS0 f-yR lyf2WYI-0i2y/Fw2Y uS0iS0 2f 0dzWuSy0 . { tY

/L{ wS0iS0SR Yes N/A No 0SElJfI-ly 0K0 y200

. { t wS0iS0SR Yes N/A No 0SElJfI-ly 0K0 y200

Medical Diagnoses

Hearing Impairment: ☐ Yes ☐ No
 Vision Impairment: ☐ Yes ☐ No

Note: If there is a hearing impairment call Deaf Services and complete Hearing Loss Checklist as addendum.

t2uSy0f aSR0i-t 0i-dzSa t2W /W0A . SKI-0i2W 2W 9EI-0S0i-0iy3 {0Y L002Y0Y

Plan of Care/Rationale

MCRS Discharge Criteria:

Disposition												
MCRS Eligibility: Choose Eligibility ☐ Clinically Excluded/Linked to Services			Assessment Completed Date & Time: Month Day Year Hour Minute Select					Clinician Departed Location Date & Time: Month Day Year Hour Minute Select				
Disposition: (check all apply and fill in blanks as indicated) ☐ Referral CSU – Name of CSU: ☐ Referral State Hospital – Name of State Hospital: ☐ Referral Private Psychiatric Hospital – Name of Hospital: ☐ Referral Medical Facility – Name of Facility/ER: ☐ Referral to IDD In-Home Supports: ☐ Referral to IDD Out-of-Home Supports: ☐ On-Site Resolution of Crisis: ☐ Outpatient referral made: Type Name of Agency/Provider: ☐ Existing Core Provider ☐ Intensive Case Management ☐ Current Core Provider ☐ CST ☐ CSB ☐ ACT ☐ Private Provider ☐ Other ☐ Referral to 12 Step Meetings ☐ Referral to Law Enforcement: Choose type of referral to Law Enforcement ☐ No Referral Made – Reason: Choose reason for no referral ☐ Pending Disposition/Linkage ☐ State Contract Bed ☐ Other Explain:												
Legal Status: Choose Legal Status Follow-Up Needed: ☐ Transportation by Benchmark Staff: Where did Benchmark staff transport individual to? 												

Additional Information:

Clinician Completing Assessment:
 Completing Clinician's Phone Number:

Date/Time: Month Day Year Hour Minute Select