McLaren Business Products

McLaren Print System Order

Order No: 55097
Order Date: 2020-06-29
User: shirley liddell
Phone: 810-342-5333

Ship Location: Mclaren OakBridge Center PHP - Shirley Liddell
4448 Oakbridge
FLINT, MI 48532
Forms
Quantity: 500
Paragon Dept No: 43560
Dept Name: Mclaren OakBridge Center PHP
Company Number: 60

Order Total Price: 24.90

Item Number: 17613
Item Description: Behavioral Health Triage Form
Revision Date: 4/2016
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: 5 Hole Top
Misc Info:

McLaren Oak Bridge PHP
Behavioral Health Triage Form

Client Name_____ DOB_____Age_____ Adult_____ Adolescent_____ Referred By_____

Marital Status_____ Number of Children ____ Children living with client_____ Client living environment_____

Primary Language Spoken_____. Any communication barriers? Hearing_____ Speech_____ Reading_____ Writing_____
If you have a barrier what assistance do you need?_____

Do you have an Advance Directive for Health Care? Yes___ No ___
Do you have an Advance Directive for Mental Health Care? Yes___ No ___
Are you interested in receiving information on these advanced directives? Yes___ No ___

Presenting Problem: (In client's words) _____

Adolescent Presenting Problem per Parent/Guardian: _____

Goal of Treatment: _____

Natural Community Supports including spiritual_____

Learning Abilities and challenges and growth and development: Co-occurring Developmental Disability, Developmental Delays, Severe Emotional Disorder, ADD, ADHD. Do you experience any barriers to learning? (To be listed on IPOS).

Trauma assessment: Do you have a history of physical abuse? Yes___ No___ Do you have a history of emotional abuse? Yes___ No ___ Do you have a history of sexual abuse? Yes___ No___ Have you ever been raped? Yes___ No___ Have you experienced an acute trauma such as a natural disaster, severe accident or threat to life, witnessing a death or violence to someone else, or been a victim of a crime? Yes___ No_____ If yes, at what age and circumstance? Do you feel safe where you currently reside? Yes___ No ___

If yes to any of the above, are you experiencing flashbacks, nightmares, insomnia, numbness, confusion, memory loss, self injury, extreme fearfulness or terror related to the trauma? Please describe. _____

Safety Risks (to home? (To be listed in IPOS). _____

Does client have any legal issues? _____Does this client require further legal assessment? _____
Does client present with educational issues? _____Will this client need to meet with ISD for further educational assessment? _____
School Counselor name _____Phone_____
Does client present with occupational issues? _____Financial Stress?_____
Does client wish to have Vocational Rehabilitation Referral? _____

Physical/Psychosomatic: Abdominal pain ___ Nausea ___ Headaches ___ Shaking/trembling ___ Sweats/chills ___
Diff Breathing ___ Closed head injury _____Seizures _____Neurological problems _____ Migraines _____
Other Chronic Medical problems: _____

Behavioral Health Triage Form
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Spec Info: