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: ____
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____

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).
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____

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**.** ____
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____

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

Does client present with 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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PT

MR.#/P

DR.

Current Psychiatric symptoms

Oriented three spheres (Time) Yes____ No_____ (Place) Yes____ No _____(Person) Yes____ No_____

Hallucinations Auditory Visual Olfactory Tactile (Please describe) ____

____

Delusional ideation (describe) ____

____

Suicidal Ideation ____ Plan__________________ Means _______ Safety Plan ___________ Previous Attempts _______Method _________

Para-Suicidal Behavior _____ Family History Mental Illness/Sub Abuse ____

Others concerned SI/HI ______ Access to Weapons_________

Homicidal Ideations_______ Plan_________ Safety plan ______Duty to Warn needed____ Hx of assault _____ Stalking ________________

Depression 1 2 3 4 5 6 7 8 9 10 (High). **Anxiety** 1 2 3 4 5 6 7 8 9 10 (High)

Sleep disturbance Insomnia____ Hypersomnia____Frequent awakenings____ Difficulty falling asleep____Hours per night ______________

Panic attacks ____ Age when began_____ Frequency____

Hygiene Good___ Ave ___ Poor___

Compulsive Behaviors_______________ Obsessive Thoughts _____________ Angry Outbursts/Rage___________Frequency____________

Appetite Change______ Weight loss or gain last 1 month _________Memory Problems _____ Poor Concentration _____ Paranoia ________

Problems Making decisions _____ Impaired Judgement ____ Mania_____ Hygiene Good___ Ave ___ Poor___

Substance Abuse Assessment

Alcohol __________ Age onset_______Number per day__________ Days drink per week______ Use per month _______ Last drink_______

Cocaine __________ Age onset_______Amount per use _________ Days used per week_______ Use per month________ Last use________

Marijuana_________ Age onset_______Joints per day ___________ Days used per week _______Use Per month _______ Last use________

Opiates type_______Age onset______ Method of use___________ Quantity per day _________ Days per week _______Last use__________

Other drug or substance ___________________Age onset________ Method of use ____________ Days per week ______Last use ________

12 step attendance _____________ Sponsor ________________ Homegroup _______________ Last attendance ____________________

Does client have any physical problems due to substance use? ____

Treatment History

Previous Hospitalizations Mental Health __________ Substance Abuse_______________Last Hospitalization ______________________

Number of Outpatient episodes Lifetime __________ Most recent treatment episode ___________ IOP _____________ PHP ____________

Current Therapist Name_______________ Last Visit _____________ Case Manager Name ____________________ Last Appt __________

Outpatient Psychiatrist name ________________________ Last visit ____

Does client have specific preferences or preferences for continued treatment?__________________________________

____

Medications

Is client currently on psychotropic medications? Yes _____ No _____

Has client stopped any medications recently? Yes _____ No _____ If Yes What? ____________________Why?_____________________

(Please see Medication reconciliation sheet for current list of medications).

Does this client meet clinical criteria for Partial Hospital Services? Yes_____ No______ If no client was referred to____________________

Notes or Additional Information.

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Screening Completed By ____ Credential _________________ Date __________________

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DR.