McLaren
NORTHERN MICHIGAN

BEHAVIORAL HEALTH SCREEN

Date: **CMH Staff/Time of approval for screen:**	
Patient Name: **DOB:** **Age:** ☐ **Male** ☐ **Female**	
Time Screen Started: Time Screen Ended: Time Faxes Received:	
Psychiatrist Paged & Time(s) Paged:	
☐ Voluntary ☐ Involuntary ☐ Petition ☐ 1st. Cert. ☐ Deferred ☐ Court Order	
Approval Time: Admitting Diagnosis:	
Admit to: ☐ **Inpatient BHU** ☐ **PHP** ☐ **Geriatric BHU** ☐ **Admit to Dr.:**	
Patient Address:	**Patient's Current Location:** ☐ **ER** ☐ **Med. Floor** ☐ **Other Facility Name:**
Phone #:	☐ CMH Screen ☐ CMH Screen
Soc. Sec. #:	BH Staff Completing Screen
Marital Status: Veteran: ☐ Yes ☐ No	Name of Caller/Company
PCP: Contacted: ☐ Yes ☐ No	Caller's Phone #:
Psychiatrist:	Patient's Legal Status:
Previous In-pt. (Where/When):	Out-pt. Treatment:
Therapist Case Manager:	Guardian Name: Phone #:
(1) Primary Insurance Phone #:	(2) Secondary Insurance Phone #:
Card #:	Card #:
(1) Subscriber's Name/DOB: (2) Subscriber's Name/DOB: Relationship to Patient:	# of Days Authorized: Contact Person/Phone #: Authorization #:
Presenting Problem:	

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ADDRESSOGRAPH

Suicidal Ideation: ☐ Yes ☐ No ☐ Plan:	Previous Suicide Attempt: ☐ Yes ☐ No When:
Current Suicide Attempt: ☐ Yes ☐ No Describe:	Self-Harm Behavior: ☐ Current ☐ History Self-Mutilation: ☐ Current ☐ History
Perceived Loss/Stressors:	Describe Self-Harm/Mutilation Behaviors:
Sexual/Physical/Emotional Abuse:	Assaultive/Destructive Behavior:
Homicidal Ideation:	Poor Impulse Control:
Restraints or PRNs:	Disoriented or Mentally Impaired:
Hallucinations: ☐ Auditory ☐ Visual ☐ Tactile ☐ Command: ☐ To Harm Self ☐ To Harm Others Explain:	
Bizarre Behaviors/Paranoia:	Delusions:
Sleep or Nutritional Disturbance:	Family History:
Substance Abuse/Drug of Choice:	
Urine Drug Screen:	Alcohol Level:
Medical Issues:	Smoker: ☐ Yes ☐ No How Much:
Diabetes: ☐ Yes ☐ No Glucose:	HTN, Stroke, Heart Disease, Pacemaker:
Seizures/Blackouts:	Bleeding/Bruising/Wounds:
Recent Falls, Injuries, Head Injuries:	Shortness of Breath, Chest Pain, Sweating:
Pain:	CPAP or O2:
☐ Ambulatory ☐ Walker ☐ Cane ☐ Wheelchair	ADLs: ☐ Independent ☐ Assisted
☐ Continent ☐ Incontinent	PICC Line/IV Access: ☐ Yes ☐ No Dialysis: ☐ Yes ☐ No
Recent hospitalization for medical condition: ☐ Yes ☐ No	
Patient's Pharmacy	Employer:
Current Medications:	
Compliant with Medications: ☐ Yes ☐ No	Allergies:
Labs Done: ☐ Yes ☐ No Abnormal labs:	
Special Precautions/Special Needs/Contact Precautions:	
Medically Cleared By: Date: Time:	
Screen Denied: ☐ Yes ☐ No If yes, reason why/time:	
RN Reviewing Screen:	

BEHAVIORAL HEALTH SCREEN

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