Region 3 Youth Crisis Response-MH Screening and Response

Initial Referral Received By *(Please Print)*: _____
Agency:_____
Type of Contact: ___Phone ___ Face to Face ___Telehealth ___ Referral to Other Services **Date of Contact:** _____

Youth Name:		**Address:**	**City/State/Zip:**
Legal Guardian Name:		**Relationship**	**Insurance:** __Medicaid __Private Insurance __None __Other:_____
Phone #:	**Type of Phone:**	**County of Residence:**	**County of Admission:**
SS#:	**Date of Birth:**	**Gender:** __Male __ Female __Transgender __Unknown	

Race: __American Indian/Alaskan Native __Asian __Black/African American __ Native Hawaiian /Other Pacific Islander __White __Other:
Ethnicity: __Unknown __ Non Hispanic __ Hispanic (ck one): __Mexican __Puerto Rican __ Cuban __Dominican __Central American __ South American __Other Hispanic Origin

Marital Status of youth: __never married __cohabitating __divorced __married __separated __widowed __unknown

Employment Status: __student __Active/Armed Forces(<35 hrs) __Active/Armed Forces (35+hrs) __disabled __employed full-time(35+hrs) __employed part-time <35 hrs __homemaker __resident of institution __sheltered workshop __supported employment __unemployed (layed off/looking) __unemployed (not seeking) __volunteer __unknown

Presenting Situation

Crisis Location: __residence __hospital __jail __unknown __other:_____

Crisis Situation: __disorderly __neglect of self care __intoxication __theft/property crime __suicide attempt/threat __threats or violence __action of a sexual nature __unknown __other:_____

Crisis Dangerousness: __Unpredictable, impulsive, violent __History of violent or impulsive behavior __Ambivalent suicidal/homicidal ideas or gestures __Suicidal/Homicidal ideation with control __Unable to meet needs in manner threatening to self __No violent or impulsive ideation or behavior

Referral Source

Referred By (Name and Agency):	**Law Enforcement Involved?** __ Yes __ No	**Name of Officer:**	**Badge Number:**

Description of Crisis:

What Led to the Youth Being Referred for Services? (check all that apply)

__ **Adjustment-related issues (changes in behaviors or emotions due to significant life stress)**
__ **Anxiety (fears, phobias, social avoidance, obsessive compulsive behavior, pstd)**
__ **Attachment problems**
__ **Behavioral concerns (aggression, defiance, acting out, impulsivity, recklessness, excessive over activity)**
__ **Conduct/delinquency-related behaviors (physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact)**
__ **Depression (dysthymia, sleep disorders, somatic complaints)**
__ **Eating disorders (anorexia, bulimia)**
__ **Excessive crying/tantrums**
__ **Excluded from preschool/daycare b/c of behavior**
__ **Home unable to meet youth's needs**
__ **Hyperactive and attention-related behaviors (impulsive, attentional difficulties)**
__ **Learning disabilities**
__ **Persistent noncompliance**
__ **Pervasive developmental disorders (autistic behaviors, social avoidance)**
__ **Psychotic behaviors (hallucinations, delusions, strange or odd behaviors)**
__ **School/Educational performance**
__ **Self-injury (hair pulling, cutting)**
__ **Sleeping problems**
__ **Suicide-related thoughts or actions (ideation/attempt)**
__ **Substance use, abuse, dependency**
__ **Other concerns related to health (cancer, illness, disease)**
__ **Other (specify):**_____

Mental Health History

Psychiatric and Medical History:	**Current medications (please list): Med compliant __yes __no**

Most current diagnosis, date of diagnosis, and who made the diagnosis:

Substance Use History

	Primary Substance	Secondary Substance	Tertiary Substance
Substance Used			
Age of First Use			
Frequency of Use	__daily __3-6 x's in past wk __1-2 x's in past wk __1-3 x's in past mth __no use in past mth __not collected __unknown	__daily __3-6 x's in past wk __1-2 x's in past wk __1-3 x's in past __no use in past mth __not collected __unknown	__daily __3-6 x's in past wk __1-2 x's in past wk __1-3 x's in past mth __no use in past mth __not collected __unknown
Volume of Use			
Route of Use	__unknown __IV __nasal __oral __other __smoke	__unknown __IV __nasal __oral __other __smoke	__unknown __IV __nasal __oral __other __smoke

Criminal History

__arrest __incarceration __victim of crime

Support System Involvement

Family/friends/ other supports: __available __questionable __some but difficult to mobilize __some but effectiveness limited __none
Agencies involved: __Mental health __Physical health __Substance Abuse __Developmental Disabilities __School __Early Intervention __Child Protection __Probation
__Other:

Ability to Cooperate

__willing/able to cooperate __wants help but is ambivalent/unmotivated __passively accepts help __little interest/comprehension __unable/unwilling to cooperate

Trauma Screening

__exposure to violence __sexual/physical/emotional abuse __neglect __witness to domestic abuse __sexual assault/rape __victim/witness to community violence __death/ loss __physical assault __victim of crime __prostitution/sex trafficking __disasters (tornado) __victim of a terrorist act war/political violence/torture __trauma while institutionalized __none identified

Suicide Risk Screening

Suicidal Behavior	Has your child ever tried to kill him/her self? __Yes __No If Yes, was it in the past 6 months? __Yes __No At any time in the past 6 months, did your child seriously *think* about trying to kill him/her self? __Yes __No
Access to Lethal Means	__access to weapons (guns, knives) __access to other lethal means (pills, poison) ***If lethal means are accessible and risk level indicates need, complete "Plan to Restrict Lethal Means" section below***

Plan to Restrict Lethal Means:

Safety Plan (Required)

To address/reduce current risk (must be completed) (*examples: medication, setting, therapy, contact with significant others, consultation):*

Safety Plan Signed/Agreed upon: __Yes __ No __Copy offered to consumer

Crisis Disposition

Outcome of Crisis: __EPC __CPC __Voluntary Hospitalization __Medical Hospitalization __No EPC, Agreed to Post-Crisis Services __No EPC, Declined Post Crisis Services __ Arrest/jail __No further action needed __Refused

Placement: __Youth remained in home (1) __ Youth Placed informally with relatives, friends (2) __ Youth formally placed out of home (foster care, detention, shelter) (3) __ Youth admitted to inpatient psychiatric unit (4)

Possible Child Abuse/Neglect: __Yes __No CPS Called: __Yes __No (800) 652-1999 If no, list reason:
Abuse of Vulnerable Adult: __Yes __No APS Called: __Yes __No (800) 652-1999 If no, list reason:

Level of Care Referred

__Outpatient/MH Therapy __Outpatient/SA Therapy __Medication Management __SA Evaluation __MH evaluation __Primary Medical Care
__Inpatient-Voluntary __Inpatient-EPC __Hospital/ER __CSU Admission __Multisystemic Therapy __IOP
__Professional Partner Program __Families CARE __Community Support /MH __Community Support/SA __ERCS __Day Rehab
__ Day Support __Domestic Violence/Sexual Abuse Agency __Nebraska Helpline __Early Development Network
__Other (list): _____

Provider Signature: **Date:**

Response Time in Minutes: **Amount of Time with Youth/Family in minutes:**

Remember to notify the family that Region 3 will be following up within 30 days to offer additional services and supports.