☐ Adult (age 18+)
☐ Child (age 10-17)

SCLARC Triage Team

Mental Health Screening Tool

Referral Date _____

Referring SC _____

****If this is an emergency, please call 911****

IDENTIYING INFORMATION

Name_____ Date of Birth _____ UCI _____

☐ Male ☐ Female Conserved: ☐ Yes ☐ No Caregiver/Guardian _____ Phone: _____

SCLARC Diagnosis _____ Other Behavioral Health Diagnoses _____

Residence: ☐ Family ☐ Group Home ☐ Lives Independently

Current Location (e.g. jail, hospital, etc.)_____

Address: _____ City: _____ Zip: _____ Phone: _____

☐ **Required consent completed** Language requirements _____

CHECK ALL THAT APPLY

Adult:

- ☐ Suicidal/Homicidal preoccupations or behaviors
- ☐ Emergency room visit in last 3 months due to mental health
- ☐ Psychiatric hospitalization (last 6 months): ☐ Currently Hospitalized? ☐ >2 hospitalizations in past 12 months
- ☐ At risk of losing placement (residential, school, or day program)
- ☐ Concerns of neglect or abuse
- ☐ Active substance abuse
- ☐ Referral to crisis response in past 12 months

Child:

- ☐ At least one psychiatric hospitalization in the past year
- ☐ At least one referral to crisis response in the past year
- ☐ Emergency room visit in the past three months due to mental health
- ☐ Suspected abuse or neglect
- ☐ Suicidal or homicidal preoccupations or behavior
- ☐ Self harm or aggression
- ☐ Frequent tantrums

- ☐ Trauma/loss/grief
- ☐ A history of being bullied
- ☐ Adjustment issues
- ☐ At risk of losing home/school placement due to behavior
- ☐ Identified as being high risk for one of the above profiles
- ☐ Active substance abuse

CURRENT PLACEMENT

Residence

☐ Foster Placement. Please provide name and contact information for foster parents.

_____

☐ If individual lives with family, spouse, and children, please provide name and relationship of those who live in home:

Name	Relationship to Consumer
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ Individual lives in a group home. Please provide name and address of group home:

_____

Judicial Involvement

☐ Currently incarcerated

Please provide a brief history of arrests and incarcerations:

_____

School

☐ Individual attends school. Please provide school district, name o school, and address of school:

_____

Program

☐ Individual attends a program. Please provide name and address of program:

_____

☐ **Individual is at risk of losing placement**

PHYSICAL HEALTH

☐ Individual has physical health impairment(s). Please list health impairments:

_____

_____

☐ Individual has a physical disability. Please list disability/disabilities:

_____

_____

☐ Individual takes medication. Please list medications and why they are taken:

Name of medication	Reason for medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH INSURANCE AND PROVIDERS

Individual has health insurance: ☐ Yes ☐ No

Please provide name of health insurance plan:

_____ Member ID #_____

Type of Insurance: Private/Commercial Plan ☐ Medi-Cal ☐ Other ☐ _____

Please provide the name, address, and phone number of primary care physician:

_____

_____

Please provide the name, address, phone number and type (e.g. psychiatrist) of mental/behavioral health providers the individual is currently seeing:

Name of clinician or agency	Address	Phone	License Type
_____	_____	_____	_____
_____	_____	_____	_____

Other Agencies & Services

☐ **DCFS Involvement**

- Please provide name and contact information for social worker:

_____

☐ **Behavior Therapy (e.g. ABA)**

- Funded by SCLARC or Health Insurance? _____
- Please provide name and contact information for agency and therapist:

_____

☐ **IEP**

- School District Eligibility Category _____
- Services received from school district _____

☐ **Please list any other agencies or services supporting individual (including services funded by SCLARC):**

Agency Name	Service Received	Case Worker Name & Contact Information
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Narrative and Summary of Pertinent Information

_____

_____

_____

_____

_____

_____

_____

SCLARC Contact Information:

	Name:	Phone:	Email:
Service Coordinator	_____	_____	_____
Education Specialist	_____	_____	_____
Mental Health Coordinator	_____	_____	_____
Project Assistant	_____	_____	_____
Clinical Director	_____	_____	_____

For Receiving Clinician Use

Outcome: ☐ Date Risk Assessment Completed ___/_____/_____

☐ Consumer or Guardian/Caregiver Declined

☐ Unable to Contact After Three Attempts (Dates attempted _____)

Date Results forwarded to MHSA Triage Team (please CC Service Coordinator) ___/_____/_____

☐ ***RISK ASSESSMENT ATTACHED***