SCLARC Mental Health Risk Assessment Tool

Referral Date _____

Referring SC _____

CONSUMER INFORMATION

Name_____ Date of Birth _____ UCI _____ ☐ Male ☐ Female

SCLARC Diagnosis _____

Date of risk assessment: _____/_____/_____

Risk Assessment Completed with: (check all that apply): ☐ Consumer ☐ Caregiver/Guardian ☐ Other

List the names and relationship of those who provided information:

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

Risk Assessment Completed: ☐ By Phone ☐ Face to Face

Location of risk assessment (if face to face):

_____

SAFETY

Suicidal preoccupations or behaviors (check all that apply)

☐ **No Suicidal ideation present**

- ☐ Suicidal **Ideation** (thoughts only)
- ☐ Specific **Plan** to suicide
- ☐ **Means** to suicide
- ☐ Specific **Intent** to suicide
  - o Hospitalization initiated by clinician: ☐ Yes ☐ No
    Outcome: _____
    _____
- ☐ Recent Suicide **Attempt** (past 30 days) Provide details below
- ☐ Past suicide attempts :
  - o Date(s) _____

- Method(s) _____
- Past Psychiatric Hospitalizations due to suicide attempt: ☐ Yes ☐ No

Homicidal preoccupations or behaviors (check all that apply)

☐ **No Homicidal ideation present**

- ☐ Homicidal **Ideation** (thoughts only)
- ☐ Specific **Plan** to hurt someone
- ☐ **Means** to hurt someone
- ☐ Specific **Intent** to hurt someone
  - Name(s) of intended victim(s) _____
  - Intended victim and Police notified: ☐ Yes ☐ No Date _____
- ☐ Recent Homicide **Attempt** (past 30 days) Provide details below
- ☐ Past homicide attempts :
  - Date(s) _____
  - Method(s) _____
  - Past Psychiatric Hospitalizations due to homicidal attem☐: Y☐ No
  - Judicial Involvement due to homicidal attempts: ☐ Yes ☐ No

Consumer and/or caregiver/guardian willing to plan for safety: ☐ Yes ☐ No

Components of Safety Plan:

- ☐ Accepted NAMI Lifeline 800-273-TALK (8255)
- ☐ Go to emergency room, urgent care, or call 911 if in danger to self or others
- ☐ _____
- ☐ _____
- ☐ _____

Additional Information:

_____

_____

_____

PSYCHIATRIC HOSPITALIZATIONS/EMERGENCY ROOM VISITS

Psychiatric Hospitalizations

☐ **No History of Psychiatric Hospitalizations**

- ☐ Currently hospitalized
- ☐ Number of past psychiatric hospitalizations _____
- ☐ Dates of psychiatric hospitalizations (start with most recent): _____

Emergency Room Visits Due to Mental Health

☐ **No history of emergency room visits**

- ☐ Number of past psychiatric hospitalizations _____
- ☐ Dates of psychiatric hospitalizations (start with most recent): _____

_____

Judicial Involvement

☐ **No history of judicial involvement**

- ☐ Past Arrests. Please list date(s) _____
- ☐ Type of Crime(s) _____
- ☐ Currently Arrested or Detained
  - o Date detained _____
  - o Where detained _____
  - o Projected date of release _____
- ☐ Currently on probation
- ☐ Currently on parole
- ☐ Diversion Program
- ☐ Incompetent to Stand Trial
- ☐ Welfare and Institutions Code 6500
- ☐ Next Court Date _____

Additional Information:

_____

_____

_____

SYMPTOMS

Mental Health (Check all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Paranoia
- ☐ Delusional
- ☐ Psychotic Symptoms
- ☐ Aggression
- ☐ Difficulties with Memory
- ☐ Repetitive Thoughts/Behavior
- ☐ Fatigue
- ☐ Sleep Disturbances
- ☐ Appetite disturbances
- ☐ Self-Injurious Behaviors
- ☐ Inattention
- ☐ Concentration difficulties
- ☐ Anger
- ☐ Irritability
- ☐ Mania
- ☐ Dissociation
- ☐ Isolating Behavior

☐ **Consumer has a mental health diagnosis-Please list all: _____**

_____

_____

Significant functional impairment in key areas-as compared to baseline levels (check all that apply)

- ☐ Unable to work
- ☐ Unable to perform in school/program
- ☐ Lack of self-care, grooming
- ☐ Inability to do simple chores
- ☐ Maladaptive coping mechanisms

Risk Factors (check all that apply)

- ☐ Lack of social support
- ☐ History of abuse/neglect
- ☐ History of trauma
- ☐ Judicial Involvement
- ☐ Medical Issues
- ☐ Physical Disability
- ☐ Recent loss/bereavement
- ☐ Homelessness
- ☐ Poverty
- ☐ Acculturation difficulties
- ☐ Substance Abuse
- ☐ Chronic pain

When did symptoms and decline in functioning (compared to baseline levels) begin? _____

_____

If there is a known precipitating event, please describe: _____

_____

Substance Use

☐ **No history of substance use**

- ☐ Substance use in past 30 days
- ☐ Substance use in past 90 days
- ☐ Enrolled in a Program. Name of Program _____
- ☐ Current substance use. Please list preferred substance(s), frequency, and last date of use:

Substance	Frequency	Last Used
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Information:

_____
_____
_____

SUMMARY AND CLINICAL IMPRESSION

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For Receiving Care Coordinator Use

Date Risk Assessment Received From Clinician ___/_____/_____
Date Results forwarded to MHASP Triage Team (please CC service coordinator) ____/____/____
Date scheduled to discuss at triage team meeting ____/____/____