SCLARC Mental Health Screening Tool

Referral Date _____

Referring SC _____

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

CONSUMER 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

- ☐ 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

***If one or more of these apply, please refer to a clinician.**

CURRENT PLACEMENT

Residence

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

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

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

_____

School

☐ Consumer attends school. Please provide name and address of school:

_____

Program

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

_____

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

PHYSICAL HEALTH

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

_____

_____

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

_____

_____

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

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

HEALTH INSURANCE AND PROVIDERS

Consumer 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 consumer is currently seeing:

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

Narrative of Pertinent Information

_____
_____
_____
_____
_____
_____
_____

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 MHASP Triage Team (please CC service coordinator) ___/_____/_____

☐ ***RISK ASSESSMENT ATTACHED***