Consent and MH Evalautions

SOWK 581 Week 04

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Agenda

Brief Lecture Video

Assignments for the Week

Consent form

MH Evaluations (Biopsychosocial Assessments)

Week 04 Assignments

What you are working on this week

Read Chapter 03 of the textbook

Make at least six replies across the forums

- Chapter 03 Reflection Questions
- Developing a Consent Form for the Case Study Paper
- Questions Used and Content Evaluated in Developing a Biopsychosocial Assessment
- Actor Representation of Mental Health Disorder and Mental Status Examination

Consent Forms

What you will be doing

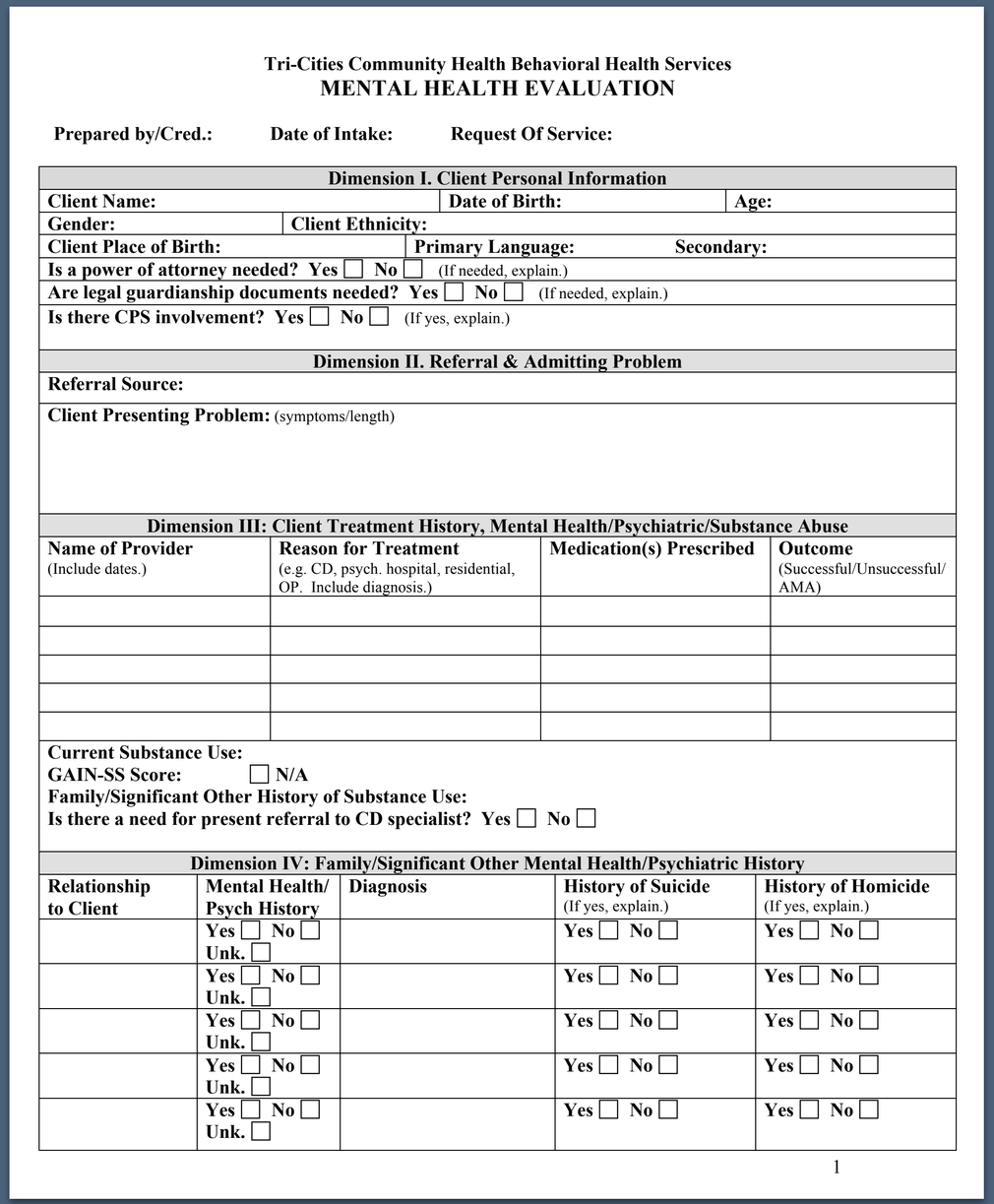
Risks/benefits

Confidentiality

Voluntary participation

Mental Health Evaluation Example

Dimension I. Client Personal Information
Dimension II. Referral & Admitting Problem
Dimension III: Client Treatment History, Mental Health/Psychiatric/Substance Abuse
Dimension IV: Family/Significant Other Mental Health/Psychiatric History



Tri-Cities Community Health Behavioral Health Services
MENTAL HEALTH EVALUATION

Prepared by/Cred.: **Date of Intake:** **Request Of Service:**

Dimension I. Client Personal Information		
Client Name:	**Date of Birth:**	**Age:**
Gender:	**Client Ethnicity:**	
Client Place of Birth:	**Primary Language:**	**Secondary:**
Is a power of attorney needed? Yes ☐ No ☐ (If needed, explain.)		
Are legal guardianship documents needed? Yes ☐ No ☐ (If needed, explain.)		
Is there CPS involvement? Yes ☐ No ☐ (If yes, explain.)		

Dimension II. Referral & Admitting Problem
Referral Source:
Client Presenting Problem: (symptoms/length)

Dimension III: Client Treatment History, Mental Health/Psychiatric/Substance Abuse			
Name of Provider (Include dates.)	**Reason for Treatment** (e.g. CD, psych. hospital, residential, OP. Include diagnosis.)	**Medication(s) Prescribed**	**Outcome** (Successful/Unsuccessful/ AMA)

Current Substance Use:
GAIN-SS Score: ☐ **N/A**
Family/Significant Other History of Substance Use:
Is there a need for present referral to CD specialist? Yes ☐ No ☐

Dimension IV: Family/Significant Other Mental Health/Psychiatric History				
Relationship to Client	**Mental Health/ Psych History**	**Diagnosis**	**History of Suicide** (If yes, explain.)	**History of Homicide** (If yes, explain.)
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**

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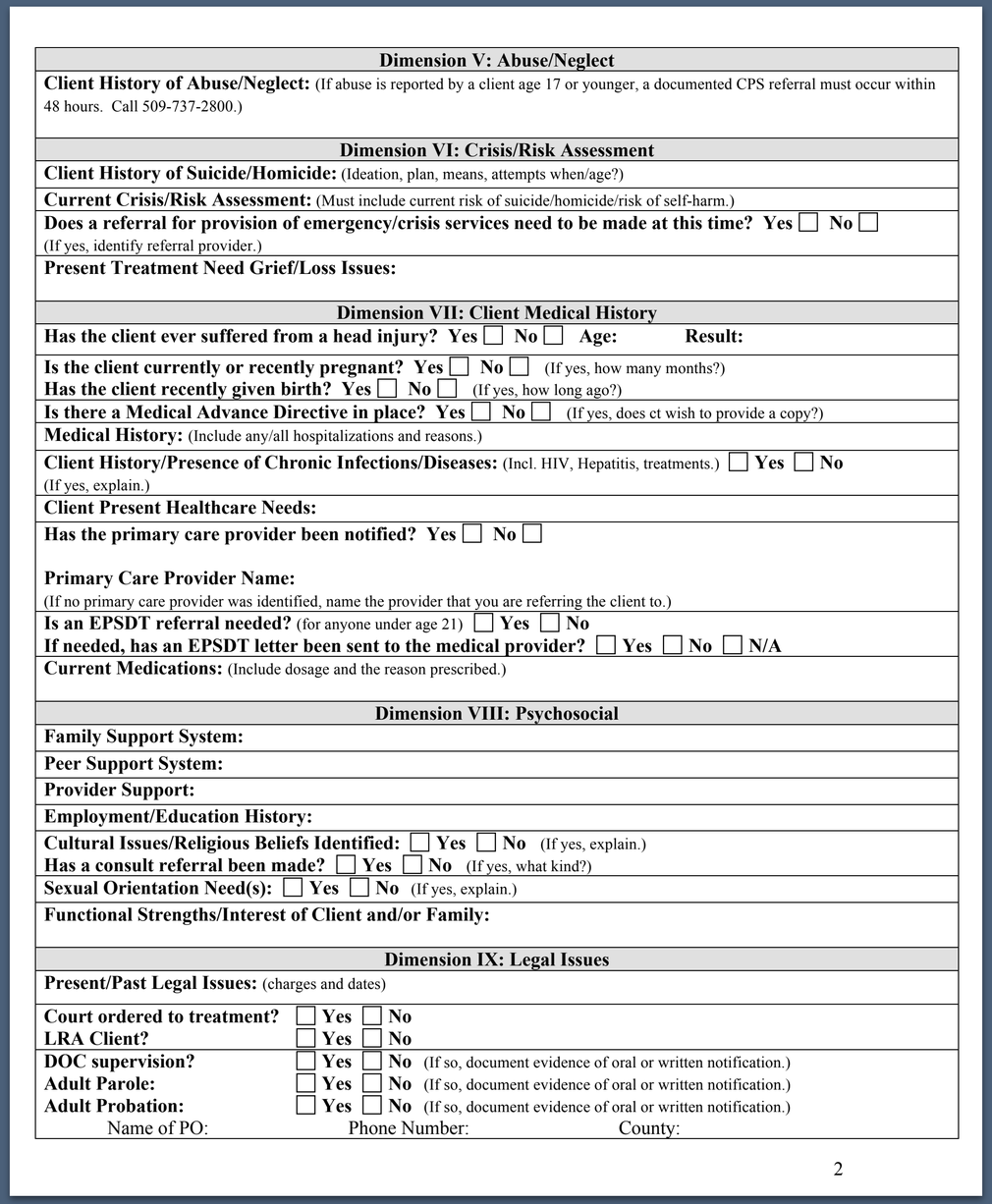


Dimension V: Abuse/Neglect
Client History of Abuse/Neglect: (If abuse is reported by a client age 17 or younger, a documented CPS referral must occur within 48 hours. Call 509-737-2800.)
Dimension VI: Crisis/Risk Assessment
Client History of Suicide/Homicide: (Ideation, plan, means, attempts when/age?)
Current Crisis/Risk Assessment: (Must include current risk of suicide/homicide/risk of self-harm.)
Does a referral for provision of emergency/crisis services need to be made at this time? Yes ☐ No ☐ (If yes, identify referral provider.)
Present Treatment Need Grief/Loss Issues:
Dimension VII: Client Medical History
Has the client ever suffered from a head injury? Yes ☐ No ☐ Age: Result:
Is the client currently or recently pregnant? Yes ☐ No ☐ (If yes, how many months?) **Has the client recently given birth? Yes ☐ No ☐** (If yes, how long ago?)
Is there a Medical Advance Directive in place? Yes ☐ No ☐ (If yes, does ct wish to provide a copy?)
Medical History: (Include any/all hospitalizations and reasons.)
Client History/Presence of Chronic Infections/Diseases: (Incl. HIV, Hepatitis, treatments.) ☐ **Yes** ☐ **No** (If yes, explain.)
Client Present Healthcare Needs:
Has the primary care provider been notified? Yes ☐ No ☐ **Primary Care Provider Name:** (If no primary care provider was identified, name the provider that you are referring the client to.)
Is an EPSDT referral needed? (for anyone under age 21) ☐ **Yes** ☐ **No** **If needed, has an EPSDT letter been sent to the medical provider?** ☐ **Yes** ☐ **No** ☐ **N/A**
Current Medications: (Include dosage and the reason prescribed.)
Dimension VIII: Psychosocial
Family Support System:
Peer Support System:
Provider Support:
Employment/Education History:
Cultural Issues/Religious Beliefs Identified: ☐ **Yes** ☐ **No** (If yes, explain.) **Has a consult referral been made?** ☐ **Yes** ☐ **No** (If yes, what kind?)
Sexual Orientation Need(s): ☐ **Yes** ☐ **No** (If yes, explain.)
Functional Strengths/Interest of Client and/or Family:
Dimension IX: Legal Issues
Present/Past Legal Issues: (charges and dates)
Court ordered to treatment? ☐ **Yes** ☐ **No** **LRA Client?** ☐ **Yes** ☐ **No**
DOC supervision? ☐ **Yes** ☐ **No** (If so, document evidence of oral or written notification.) **Adult Parole:** ☐ **Yes** ☐ **No** (If so, document evidence of oral or written notification.) **Adult Probation:** ☐ **Yes** ☐ **No** (If so, document evidence of oral or written notification.) Name of PO: Phone Number: County:

Mental Health Evaluation Example

Dimension V: Abuse/Neglect

Dimension VI: Crisis/Risk Assessment

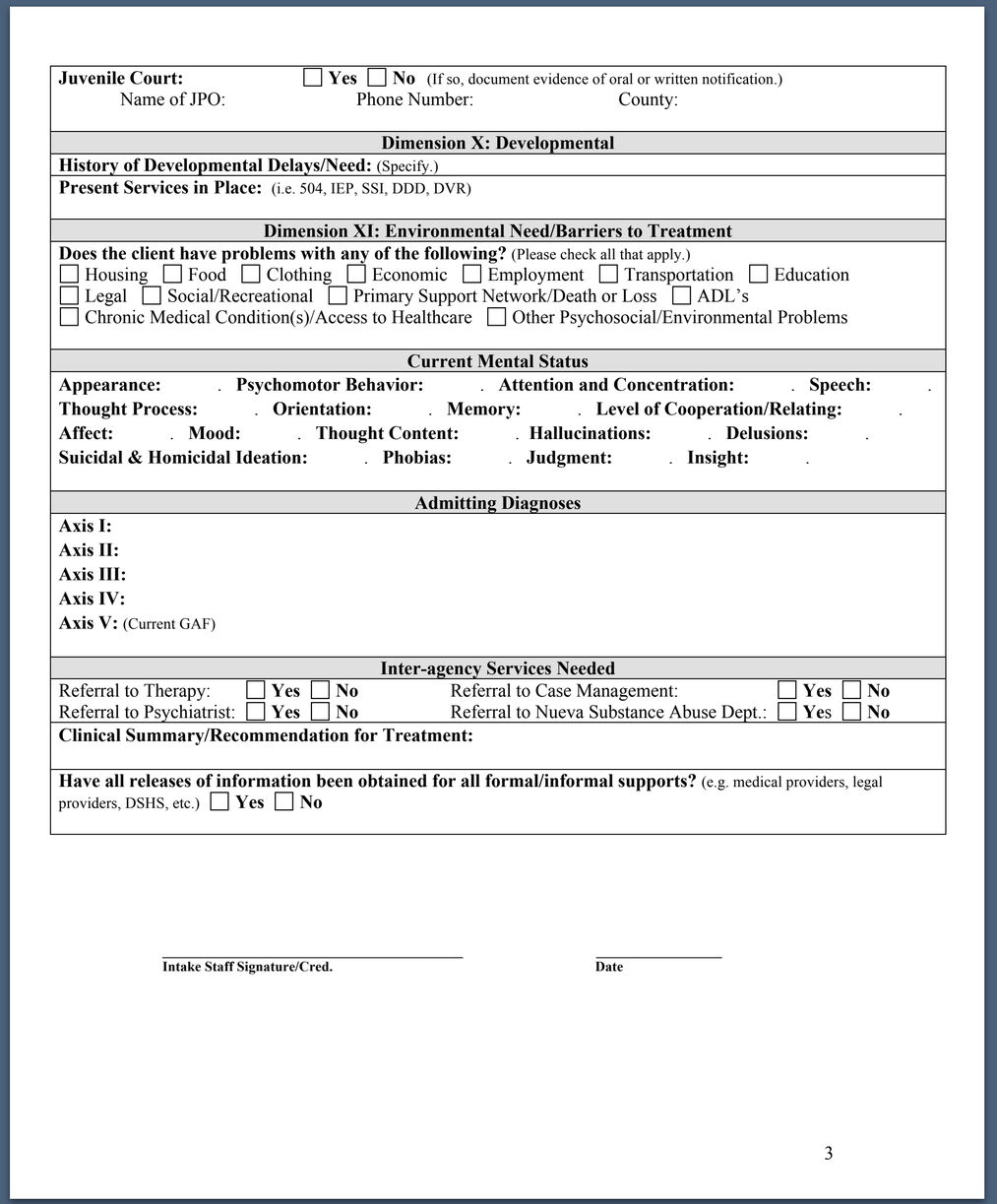
Dimension VII: Client Medical History

Dimension VIII: Psychosocial

Dimension IX: Legal Issues

Mental Health Evaluation Example

Dimension X: Developmental
Dimension XI: Environmental Need/Barriers to Treatment
Current Mental Status
Admitting Diagnoses
Inter-agency Services Needed



Juvenile Court: ☐ **Yes** ☐ **No** (If so, document evidence of oral or written notification.)
Name of JPO: Phone Number: County:

Dimension X: Developmental

History of Developmental Delays/Need: (Specify.)

Present Services in Place: (i.e. 504, IEP, SSI, DDD, DVR)

Dimension XI: Environmental Need/Barriers to Treatment

Does the client have problems with any of the following? (Please check all that apply.)
☐ Housing ☐ Food ☐ Clothing ☐ Economic ☐ Employment ☐ Transportation ☐ Education
☐ Legal ☐ Social/Recreational ☐ Primary Support Network/Death or Loss ☐ ADL's
☐ Chronic Medical Condition(s)/Access to Healthcare ☐ Other Psychosocial/Environmental Problems

Current Mental Status

Appearance: . **Psychomotor Behavior:** . **Attention and Concentration:** . **Speech:** .
Thought Process: . **Orientation:** . **Memory:** . **Level of Cooperation/Relating:** .
Affect: . **Mood:** . **Thought Content:** . **Hallucinations:** . **Delusions:** .
Suicidal & Homicidal Ideation: . **Phobias:** . **Judgment:** . **Insight:** .

Admitting Diagnoses

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: (Current GAF)

Inter-agency Services Needed

Referral to Therapy: ☐ **Yes** ☐ **No** Referral to Case Management: ☐ **Yes** ☐ **No**
Referral to Psychiatrist: ☐ **Yes** ☐ **No** Referral to Nueva Substance Abuse Dept.: ☐ **Yes** ☐ **No**

Clinical Summary/Recommendation for Treatment:

Have all releases of information been obtained for all formal/informal supports? (e.g. medical providers, legal providers, DSHS, etc.) ☐ **Yes** ☐ **No**

_____ _____
Intake Staff Signature/Cred. **Date**

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