UNIFORM PREADMISSION SCREENING FORM

This form is to be completed by a certified preadmission screening evaluator employed or contracted by a Community Services Board to determine and arrange the least restrictive disposition for an individual in need of an emergency intervention. The disposition to be recommended at the commitment hearing shall consider all least restrictive alternatives available.

DATE_____ **TIME (from**_____ **to**_____**)**
EMERGENCY CUSTODY ORDER: Magistrate Issued? ☐Yes ☐No Date and Time Executed: _____
Law Enforcement Custody ☐Yes ☐No Date and Time Executed: _____
Extended? ☐Yes ☐No ☐To identify TDO facility ☐To complete Med Eval ☐Other_____
EVALUATION: ☐In-Person ☐Two-way electronic video and audio
DISPOSITION: ☐**VOL** ☐**TDO** ☐**SAFETY PLAN** ☐**RECOMMITMENT** ☐**OTHER (explain):** _____
NAME of HOSPITAL/FACILITY: _____ **CASE/TDO #**_____
Legal Status: _____

1. PERSONAL DATA

First Name:_____ Last Name: _____ Age:_____ Date of Birth:_____ (MM/DD/YYYY)

Address: _____ (Street) (City or County) (State) (Zip Code)

Phone: ( ) _____ Marital Status: _____ SSN:_____

Physical description: _____ (Sex) _____ (Race) _____ (Hispanic Origin) _____ (Height) _____ (Weight) _____ (Hair Color) _____ (Eye Color)

Emergency Contact: _____ Relationship to Person: _____

Address: _____ (Street) (City or County) (State) (Zip Code) Permission to contact? ☐Y ☐N

Phone: Home ( )_____ Work ( ) _____

Legal Guardian: ☐Y ☐N If yes, Name: _____ Phone: ( ) _____

SSI: ☐Y ☐N SSDI: ☐Y ☐N Employed: ☐Y ☐N Veteran: ☐Y ☐N ☐UNK

Insurance: ☐Y ☐N _____ (Name of Company/Group/Plan/Number) Medicaid: ☐Y ☐N #_____

Medicare: ☐Y ☐N? # _____ Part D: ☐Y ☐N # Name of plan: _____

(If under 18) School Division: _____ School Attending:_____ Grade: ___ Special Education: ☐Y ☐N

CSB of Residence: _____ Contacted: ☐Y ☐N ☐N/A CSB Agency Code _____

Name of CSB Staff Contacted:_____ Phone ( ) _____

2. COLLATERAL SOURCES OF INFORMATION/CSB SERVICES: (Please *check* all that apply)

☐WRAP or Other Advance Directive ☐Individual Requesting Evaluation ☐Family/Significant Other ☐Treatment Records

☐Treating physician/Psychiatrist ☐CSB Case Manager or Other Staff ☐Police/First Responders

Is this individual currently receiving CSB services? ☐Y ☐N If yes, specify: _____

In which CSB Program Area(s) (Check): ☐Behavioral Health (MH or SA) ☐Developmental (MR) Services

☐Under MOT ☐Other (Specify): _____

Primary Care Coordinator/Case Manager Name/Phone: _____

3. FOR LOCAL USE

4. PRESENTING CRISIS SITUATION AND CURRENT CIRCUMSTANCES (Including information such as what helped the person in previous crises, precipitating events, stressors, strengths, alternative decision makers, accessibility of support network, recent behaviors)

_____
_____
_____
_____
_____
_____
_____

5. MENTAL STATUS EXAM (***Check*** all that apply and add specific behaviors under findings)

Appearance: ☐WNL ☐unkempt ☐poor hygiene ☐bizarre ☐tense ☐rigid

Behavior/Motor Disturbance: ☐WNL ☐agitation ☐guarded ☐ tremor ☐ manic ☐ impulse control ☐ psychomotor retardation

Orientation: ☐WNL **disoriented**: ☐time ☐place ☐person ☐situation

Speech: ☐WNL ☐pressured ☐slowed ☐soft/loud ☐impoverished ☐ slurred ☐other

Mood: ☐WNL ☐depressed ☐angry/hostile ☐euphoric ☐anxious ☐ anhedonic ☐withdrawn

Range of Affect: ☐WNL ☐constricted ☐flat ☐labile ☐inappropriate

Thought Content: ☐WNL ☐delusions ☐grandiose ☐ideas of reference ☐paranoid ☐obsessions ☐phobias

Thought Process: ☐WNL ☐loose associations ☐flight of ideas ☐circumstantial ☐blocking ☐tangential ☐perseverative

Perception/ Sensorium: ☐WNL **hallucinations:** ☐ auditory ☐ visual ☐ olfactory ☐ tactile ☐ illusions

Memory: ☐WNL **impaired**: ☐recent ☐remote ☐immediate

Able to provide historical information: ☐Y ☐N If no, explain below in findings.

Appetite: ☐WNL ☐poor **Weight**: ☐loss ☐gain **Appetite**: ☐increased ☐decreased

Sleep: ☐WNL ☐hypersomnia ☐ onset problem ☐ maintenance problem

Insight: ☐WNL ☐blaming ☐little ☐none **Judgment**: ☐Good ☐Impaired ☐poor

Estimated Intellectual/Functional Capacity: ☐above average ☐average ☐below average ☐diagnosed MR

Reliability of self report (explain below) ☐good ☐fair ☐poor

Explain clinically significant findings, including areas unable to assess:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Individual's Name: _____

6 DIAGNOSIS: DSM IV (P=Provisional, H=Historical)

Axis I:_____ **Axis I:**_____ **Axis I:**_____

Axis I:_____ **Axis I:**_____ **Axis I:**_____

Axis II:_____ **Axis II:**_____

Axis III: : ☐**Y** ☐**N** **Condition:** _____

Axis IV: Psychosocial and Environmental (Check): ☐Support Group ☐Social Environmental ☐Educational
☐Occupational ☐Housing ☐Economic ☐Health Care ☐Legal System/Crime ☐Other: _____

Axis V: GAF Current: _____ Highest past year, if known: _____

7. RISK ASSESSMENT/Clinical Opinion:

Mental Illness: ☐Is ☐Is Not a person with mental illness Substance Abuse: ☐Is ☐Is Not a person abusing substances.

Temporary Detention Order and Civil Commitment Criteria (Please ***Check*** all that apply)

☐There is a substantial likelihood of serious physical harm to ☐self or ☐others in the near future as a result of mental illness as evidenced by recent behavior:

☐Caused Harm ☐Current Attempt ☐Recent Attempts to Harm ☐Threatening Harm
☐Ideation Plan: ☐Defined ☐Means ☐Active psychosis

Please describe information checked above/recent behavior:

_____
_____
_____
_____

☐ Other relevant information, if any, specify:

_____
_____
_____
_____

☐There is a substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to a lack of capacity ☐to protect him/herself from harm or ☐to provide for his/her basic human needs.*

☐Engaging in behavior that could lead to harm
☐Interventions designed to prevent harmful behavior have been ☐attempted ☐failed
Please describe information checked above/recent behavior:

_____
_____
_____
_____

Capacity & Willingness to Accept Voluntary Treatment/Hospitalization/Least Restrictive Alternatives

☐ Is able ☐ Is not able to maintain and communicate choice
☐ Is able ☐ Is not able to understand relevant information
☐ Is able ☐ Is not able to understand consequences
☐ Is willing ☐ Is not willing to be treated voluntarily
☐There are ☐ There are not less restrictive community alternatives than a TDO to serve this individual

Treatment and Support Options: ☐Considered or ☐Implemented _____

***Not applicable under Virginia Code §19.2-169.6, 19.2-176 and 19.2-177-1**

Individual's Name: _____

8. DISPOSITION OF THE EMERGENCY EVALUATION OR EMERGENCY CUSTODY ORDER:
(Please ***Check*** one of the following dispositions)
☐No further treatment required or ☐individual declined referral and no involuntary action taken

Note: If a TDO is not recommended you must inform the petitioner and on-site treating physician

☐Referral for voluntary outpatient or community treatment other than crisis stabilization
If any of the above are checked you may stop and sign below

If any of the following are checked, please continue completing this form

☐ Referral for voluntary crisis stabilization (residential or ambulatory)

☐ Voluntary inpatient admission and treatment

☐ Consideration of inpatient admission by designated ☐ health care agent pursuant to advance directive

_____
Name of Agent

or ☐ guardian _____ pursuant to guardianship order.
Name of Guardian

☐TDO Please ***Check*** if you have ☐explained the TDO and commitment hearing process to the ☐individual and notified ☐family member or ☐ personal representative of the person's location and general condition, specify name(s): _____
☐ Recommend alternative transportation by (name) _____ or ☐ Do not recommend
Consulted with Magistrate about alternative transportation ☐ Yes ☐ No

Preadmission Screener Signature: _____ **Print Name & CSB** _____

9. MENTAL HEALTH TREATMENT HISTORY (Attach WRAP plan or advance directive if available): If individual has had inpatient hospitalization(s): 1)a. Approx. number of total hospitalizations _____ 1)b. State facility?: ☐Y ☐N
2)a. Discharge date of last hospitalization _____ 2)b. From where?: _____

Comments (optional): _____

Psychiatrist/Private Provider: _____ Contact Info: _____

10. MEDICAL Primary Care Provider: _____ Phone (____) _____

Medical History & Current Medical Problems/Symptoms: _____

Medication: current prescribed psychotropic and other medications (including dosage, schedule, etc., if known)

Name	Dose	Schedule	Name	Dose	Schedule
1.			7.		
2.			8.		
3.			9.		
4.			10		
5.			11. ☐Please see attached medication list		
6.			12. ☐Please see attached medical addendum		

Has individual followed recommended medication and recovery plans? ☐Y ☐N ☐NA If no, please explain:

Recent medication changes: ☐Y ☐N (If yes, add date if known & explain)

Allergies (including food) or adverse side effects to medications: ☐Y ☐N (If yes, explain) _____

Individual's Name: _____

11. SUBSTANCE ABUSE ASSESSMENT And TREATMENT HISTORY: ***Check*** if no current use ☐ or please ask the individual the following questions:

Have you consumed alcohol or drugs in the last 30 days? ☐Yes ☐No Date of Last Use: Alcohol _____ Drugs _____

What drugs have you used in the past?

Have you or anyone else ever felt you had a drug or alcohol problem? ☐Yes ☐No

Have you ever experienced withdrawal from drugs or alcohol? ☐Yes ☐No If yes, check alnythat apply: ☐Tremors ☐ Headaches
☐Vomiting ☐Nausea ☐Diarrhea ☐Sweating ☐Paranoia

☐Individual refused to answer questions about drug or alcohol use

BAC: _____ Lab Results: _____ Unable to Test: _____

Please check if occurred in
PAST 24 HOURS: ☐Tremors ☐Seizures ☐DTs ☐Vomiting -Blood present? ☐Y☐N ☐Diarrhea -Blood present?☐Y☐N

If individual has received inpatient detox services: A)Number of times in detox? _____ B)Discharge date of last detox service: _____

C) From where?:

_____
_____
_____
_____

12. LEGAL DATA

A) Is individual serving a sentence? ☐Y ☐N Explain, if known: _____

B) NGRI Conditional Release?: ☐Y ☐N C) On Probation/Parole?: ☐Y ☐N Contact: _____

D) Pending Legal Charges?: ☐Y ☐N If known: nature of charges: _____
Date of hearing: _____ Court of Jurisdiction: _____

13. INDIVIDUAL SERVICE PLANNING

Individuals who can assist in treatment planning (i.e., family, peer specialist, case manager, therapist, etc.)

	Name	**Phone No.**	**Relationship to Person**	**Does the individual want this person involved in his/her care?**
1.				Yes☐ No☐
2.				Yes☐ No☐
3.				Yes☐ No☐

Preadmission Screener Signature: _____ **Date**: _____

Print Name:

Section 14 on page 6 need not be completed prior to referral for temporary detention order, but must be completed prior to the hearing.

Individual's Name: _____

Section 14 below need not be completed prior to referral for temporary detention order, but must be completed prior to the hearing.

14. CSB REPORT TO THE COURT AND RECOMMENDATIONS FOR THE INDIVIDUAL'S PLACEMENT, CARE AND TREATMENT PURSUANT TO 37.2-816.

Date: _____ Time: _____ Name of Individual: _____

(Please ***Check*** all that apply) ☐ No further treatment required

☐ Has or ☐ does not have sufficient capacity to accept treatment

☐ Is or ☐ is not willing to be treated voluntarily, therefore the CSB recommends:

☐ Voluntary community treatment at the ☐ CSB, specify: _____

☐ Other, specify: _____

☐ Voluntary admission to a crisis stabilization program, specify name of program: _____

☐ Voluntary inpatient treatment because the individual requires hospitalization and has indicated that he/she will agree to a voluntary period of treatment up to 72 hours and will give the facility 48 hours notice to leave in lieu of involuntary admission.

☐ Meets the criteria for involuntary admission or mandatory outpatient treatment as follows: (***Check*** all applicable)

☐ There is a substantial likelihood of serious physical harm to ☐ self or ☐ others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or

☐ There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to a lack of capacity ☐ to protect him/herself from harm or ☐ to provide for his/her basic human needs

Therefore the CSB recommends: (***Check*** A or B)

A. ☐ Mandatory outpatient treatment because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and ☐ are deemed to be appropriate, and the person ☐ has sufficient capacity to understand the stipulations of his/her treatment, ☐ has expressed an interest in living in the community and ☐ has agreed to abide by his/her treatment plan, and ☐ is deemed to have the capacity to comply with the treatment plan and ☐ understand and ☐ adhere to conditions and requirements of the treatment and services. The recommended treatment ☐ can be delivered on an outpatient basis by the ☐ CSB or ☐ designated provider(s), specify: _____

Core Service	***Program Area***	
Outpatient Services	☐ Behavioral Health (MH or SA)	☐ Developmental (MR) Services
Case Management	☐ Behavioral Health (MH or SA)	☐ Developmental (MR) Services
Day Support	☐ Behavioral Health (MH or SA)	☐ Developmental (MR) Services
Employment	☐ Behavioral Health (MH or SA)	☐ Developmental (MR) Services
Residential	☐ Behavioral Health (MH or SA)	☐ Developmental (MR) Services
☐ Consumer Run Services	☐ Behavioral Health (MH or SA)	☐ Developmental (MR) Services

Additional Recommendations for Community Services:

☐ Wellness Recovery ☐ Peer Specialist Support ☐ Housing ☐ Transportation ☐ Financial Support Entitlement

☐ Dental Services ☐ Nutritional ☐ Primary Health Care ☐ Nursing Home Care

☐ Legal Assistance/ Advocacy ☐ Trauma Informed

☐ Other, specify: _____

Services checked above are ☐ actually available in the community and ☐ providers have actually agreed to deliver the services.

B ☐ Involuntary admission and inpatient treatment not to exceed ☐ 30 days (initial) ☐ not to exceed 180 days (subsequent)

☐ There are no less restrictive alternatives to inpatient treatment

☐ Recommend alternative transportation by (name) _____ ☐ Do Not Recommend Alternative Transportation

_____ _____

Preadmission Screener Signature Date Preadmission Screening/Board

_____

Print Name Here

_____ _____

CSB Hearing Representative Signature Date Hearing Representative CSB

Individual's Name: _____

UNIFORM PREADMISSION SCREENING FORM SUPPLEMENT

Individual's Name: _____

PERSONAL ADDENDUM

(As appropriate, individual receiving emergency services shall be offered the following opportunity to comment at the time of the preliminary evaluation and prior to the commitment hearing)

Individual has been given an opportunity to comment::
☐ **Yes (see below comments)** ☐ **Yes, and does not choose to comment**
☐ **No, explain:**

_____
_____
_____

INDIVIDUAL COMMENTS

1. How would you describe the current situation?

_____
_____
_____
_____

2. What do you think would be the most helpful to you right now?

_____
_____
_____
_____

3. Are there any particular people you would like to be involved in your care and treatment (such as family members, friends, peers)?

_____
_____
_____
_____

4. Are there things you've already tried to help manage the current situation?

_____
_____
_____
_____

5. What are your top three strengths?

_____
_____
_____
_____

6. Would you like to comment on anything else?

_____
_____
_____
_____

Individual's Name: _____

Individual's Signature _____ Date: _____