

Community Services Board/Behavioral Health Authority: _____ Consumer ID# _____

Date: _____ Time: From _____ am pm To _____ am pm
 Time under court order: _____ Time not under court order: _____

Emergency Custody Order: Yes No Magistrate Issued Law Enforcement Issued (Paperless)
 Date and Time Executed: _____
 Extension: Yes No Reason: _____ (identify facility/medical evaluation/other good cause)
 Evaluation: In-person or Two-way electronic video and audio
 Petitioner _____ Phone: _____
 Translator and language: _____ Phone: _____

DISPOSITION Recommitment TDO Voluntary CSU Safety Plan Release Referral Other _____

HOSPITAL/FACILITY _____ Case/TDO #: _____

Personal Information

First Name: _____ Middle: _____ Last Name: _____ DOB: _____ Age: _____

SSN: _____ - _____ - _____ M / F _____
 (Gender) (Race) (Hispanic Origin) (Height) (Weight) (Hair Color) (Eye Color)

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

Phone: (____) _____ Home/Cell Marital Status: _____ Spouse Name: _____

School Division (If applicable): _____ School Attending: _____ Grade: _____ Special Ed.: Y or N

(If under age 18)
 Mother: _____ Address: _____ Phone: _____ Home/Cell
 Father: _____ Address: _____ Phone: _____ Home/Cell

Legal Custodian Unknown Name: _____ Phone: _____ Address: _____
 Legal Guardian Unknown Name: _____ Phone: _____ Address: _____

Emergency Contact: Name _____ Relationship to Person: _____ Phone _____
 Address: _____
 (Street) (City) (State) (Zip Code) (County)

CSB of Residence: _____
 CSB Code: _____ Contacted: Yes No _____
 (Name) (Phone)

Employment Status: Unknown _____ Education Level: (All ages) _____
 Employer: _____ Phone: _____
 Military Status: Unknown _____ Start Year: _____ End Year: _____
 SSI Yes No Unknown SSDI Yes No Unknown

Medicaid: Yes No Unknown # _____ Subscriber Name: _____
Medicare: Yes No Unknown # _____ Part D: Yes No _____ Plan _____
Insurance: Yes No Unknown _____
 (Name of Company/ Group/Plan/Number)

Local Use

Behavioral Health Treatment/Services

Current Outpatient Treatment: Yes No Unknown Behavioral Health (MH - SA) Developmental Services

Private Provider or CSB Name: _____ Phone: _____

Case Manager: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Prior Inpatient Treatment: Yes No Unknown Behavioral Health (MH - SA) Developmental Services

Name/Location of Last Tx facility: _____ Adm. Date: _____ Discharge Date: _____

Number of Hospitalizations: _____

Ever in a State facility? Yes No Name: _____ Date: _____

Ever in a Crisis Stabilization Unit? Yes No Name: _____ Date: _____

Other: _____

<input type="checkbox"/> WRAP Plan	<input type="checkbox"/> MOT	<input type="checkbox"/> PACT/ICT	<input type="checkbox"/> NGRI	<input type="checkbox"/> Advance Directive	<input type="checkbox"/> Safety & Support Plan	<input type="checkbox"/> Group Home
<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Prevention Services	<input type="checkbox"/> In-Home Provider Name: _____			<input type="checkbox"/> Other: _____	

Substance Abuse Assessment

No current use No history of use Refuses to answer

Current use listed below:

Drug Type	Priority	Age 1 st Use	Frequency of Use and Amount	Method of Use	Date of Last Use and Amount
	Primary				
	Secondary				
	Tertiary				

History of substance abuse (Drugs, alcohol, mood altering substances, marijuana, prescription medications, inhalants)

Comment: _____

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

Have you received inpatient or outpatient SA treatment? Yes No Maintenance services? Yes No

Number of prior episodes of any drug: _____ Detoxification treatment? Yes No

Name/Location of last treatment facility: _____ Date of Discharge: _____

	Current withdrawal (Past 24 hours)	History of withdrawal
Tremors		
Headaches		
Vomiting (Blood present) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nausea		
Diarrhea (Blood present) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Sweating		
Paranoia		
DT's		
Other		

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

Tobacco use? Yes No Type: _____

Pregnant Status: Yes No Unknown Pregnant and using substances? Yes No Unknown

Name: _____

Medical

Primary Care Provider: _____ Phone: _____

Medical history and current medical symptoms or issues:

Medication: **Please see attached medication list** **Please see attached medical addendum**

Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

<u>Name</u>	<u>Dose</u>	<u>Schedule</u>	<u>Physician</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

Has individual followed recommended medication plan? Yes No Explain: _____

Has individual followed recommended recovery plan? Yes No N/A Explain: _____

Recent medication change? Yes No Unknown Date of change: _____

Describe change: _____

Allergies (including food) or adverse side effects to medications: Yes No Unknown

Describe: _____

Legal Data

Legal Status: _____ Unknown

Is individual serving a sentence? Yes No Unknown Details: _____

Is individual NGRI Conditional Release? (Adults only) Yes No Unknown Details: _____

Is individual on probation or parole? Yes No Unknown Contact Person: _____

Pending legal charges? Yes No Unknown Charges: _____

Date of hearing if known: _____ Court of Jurisdiction _____

If a minor: Judge: _____ Attorney: _____ GAL: _____

Has individual come from detention? Yes No Unknown

Juvenile Detention Center: _____

(Facility Name)

(Address)

(Telephone)

(Fax)

Diagnosis DSM IV R (P- Provisional, H-Historical)

Axis I _____ Axis I _____ Axis I _____

Axis II _____ Axis II _____

Axis III _____

Axis IV Psychosocial and Environmental (Check all that apply)

- Support group
- Social /Environmental
- Educational
- Domestic
- Occupational
- Housing
- Economic
- Health Care
- Legal System
- Other _____

Axis V GAF Current: _____

Highest past year, if known: _____

Individual Service Planning

Individuals who may be helpful in treatment planning.

Name	Telephone	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Family Member Guardian Name: _____ may be contacted with information that is directly relevant to their involvement with the individual's health care, including location and general condition.

(32.1-127.1:03(D34))

- Individual agrees Individual lacks capacity
- Individual objects Emergency makes it practically impossible to agree or object.

Outcome of the emergency evaluation or ECO

No further treatment required, or

Individual declined referral and no involuntary action taken, or

Referred to voluntary crisis stabilization unit, or

Referred to voluntary outpatient or community treatment other than crisis stabilization, or

Referred to voluntary inpatient admission and treatment,
and

Petitioner and Treating physician notified of disposition if TDO not recommended.

Recommitment recommended by CSB

TDO recommended by CSB

Hearing and commitment process has been explained to the individual.

CSB consulted with magistrate about alternative transportation Yes No

CSB does not recommend alternative transportation.

CSB recommends alternative transportation by _____
(Name)

37.2-805.1

Consideration of 10 day inpatient admission by health care agent pursuant to advance directive _____
(Name of Agent)

Consideration of 10 day inpatient admission by designated guardian pursuant to guardianship order _____
(Name of Guardian)

Risk Assessment/Clinical Options

Minor 16.1-340.1

Because of mental illness:

- The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; or
- Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, as evidenced by: delusional thinking or by a significant impairment of functioning in hydration, nutrition, self protection or self control; and
- The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment.

Findings: _____

The minor's parents/guardians were or were not consulted. The minor's treating or examining physician, if applicable, was or was not consulted.

Treatment and support options:

Inpatient treatment is or is not the least restrictive alternative that meets the minor's needs

Outpatient or less restrictive services has been tried with the following results:

Outpatient or less restrictive service has *not* been tried and is *not* likely to be adequate because:

Adult 37.2-809

It appears from all evidence readily available that the person:

- Has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future:
 - Cause serious physical harm to self or others as evidenced by recent behavior, causing, attempting, or threatening harm, and other relevant information, or,
 - Suffer serious harm due to his lack of capacity to:
 - protect himself from harm or
 - provide for his basic human needs (not applicable under Virginia Code 19.2-169.6), and
- Is in need of hospitalization or treatment.

Findings: _____

Capacity for adults and minors age 14 and older

Able to maintain and communicate choice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Able to understand consequences	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Able to understand relevant information	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Willing to be treated voluntarily	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Risk Factors

- Aggressive behavior
- Sexual acting out
- Self injurious behavior
- Elopement
- Actively psychotic
- Suicidal ideation
- Homicidal ideation
- Plan
- Access to weapons
- Other _____

Protective Factors _____

Final Disposition:

Preadmission Screening Evaluator Signature Date Board
Electronically signed

Preadmission Screening Evaluator Signature Date Board
Electronically signed

Name: _____

CSB report to court and recommendations for the individual's placement, care and treatment pursuant to 16.1-340.4 (Minor) or 37.2-816 (Adult)

Name of Individual: _____ Date: _____ Time: _____ am pm

- No further treatment required.
- Has or does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for Outpatient treatment)
- Is or is not willing to be treated voluntarily (* not applicable under Virginia Code19.2-169.6)
- Voluntary community treatment at the CSB (specify) _____
Or other (specify) _____
- Voluntary admission to a crisis stabilization program (specify) _____

Adult: Voluntary inpatient treatment because 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.

- Minor: Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older.
- Minor: Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

Minor 16.1-340.4 Under age 14 Age 14 or Older

Parent or guardian is or is not willing to consent to voluntary admission (for inpatient treatment only)

Because of Mental Illness meets the criteria for involuntary admission or mandatory outpatient treatment as follows:

- The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidence by recent acts or threats or: Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, evidenced by: delusional thinking or significant impairment of functioning in: hydration nutrition self protection self control. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment. Is the parent or guardian with whom the minor resides willing to approve any proposed commitment? Yes No Unavailable

If no, is such treatment necessary to protect the minor's life, health, safety or normal development? Yes No

❖Therefore the CSB recommends:

- A. Involuntary admission and inpatient treatment, as there are no less restrictive alternatives to inpatient treatment. Alternative transportation

B. Mandatory outpatient treatment (16.1-345.2) not to exceed 90 days because less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and determined to be appropriate; and providers of the services have agreed to deliver the services: The minor, if 14 years of age or older, and his parents or guardians have sufficient capacity to understand the stipulations of the minor's treatment, have expressed an interest in the minor's living in the community and have agreed to abide by the minor's treatment plan, and are deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services; and the ordered treatment can be delivered on an outpatient basis by the Community Services Board or a designated provider(s): specify: _____

C. Do the best interests of the minor require an order directing either or both of the minor's parents or guardian to comply with reasonable conditions relating to the minor's treatment? Yes No

Adult 37.2-816

Because of Mental Illness meets the criteria for involuntary admission or mandatory outpatient treatment (* not applicable under Virginia Code19.2-169-6)as follows:

- 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 lack of capacity: to protect him/herself from harm or to provide for his/her basic human needs (* not applicable under Virginia Code19.2-169.6).

❖Therefore the CSB recommends:

- A. Involuntary admission and inpatient treatment as there are no less restrictive alternatives to inpatient treatment. Alternative transportation

B. Mandatory outpatient treatment (37.2-817 (D))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 agreed to abide by his/her treatment plan, and has the ability to do so. The recommended treatment is actually available on an outpatient basis by the CSB or designated provider(s) specify: _____

C. Physician discharge to mandatory outpatient treatment following inpatient admission pursuant to 37.2-817 (C1) and (C2). The person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent relapse or deterioration of his condition that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment, and the person is likely to benefit from mandatory outpatient treatment.

Preadmission Screening Evaluator Signature or Electronically signed _____ Date _____

_____ Board

Print Name Here (Not required if electronically signed) _____

_____ Representative CSB

Personal Comment Section

As appropriate, the 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. If a minor, the parent or guardian may also comment.

- Individual
- Parent/Guardian
- Family member

- Yes (see comments below)
- Yes and does not choose to comment
- No, Explain: _____

How would you describe the current situation?

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

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

If parent/guardian of minor: What do you think would be most helpful to your child right now?

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

If parent/guardian of minor: Are there particular people you would like to be involved in your child's care and treatment?

What are your top three strengths?

If parent/guardian of minor: What are your child's top three strengths?

Would you like to comment on anything else?

Individual's Signature: _____

Date: _____

Parent/Guardian/Family Member Signature: (if appropriate) _____

Date: _____

