



Organization Name:	Program Name:	Date:
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Individual's Name (First MI Last):	Record #:	DOB:
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Reason for Referral and Chief Complaint/Presenting Problem

Reason for Referral and Chief Complaint/presenting problem-priority and/or emergency issues in individual's own words:

Family/Guardian description of problem (if relevant):

History of Present Psychiatric Illness (Describe course of presenting stressors/symptoms/concerns):

Past Psychiatric History (Previous episodes of current symptoms and any other past psychiatric concerns):

Substance Use/Addictive Behavior Screen

Does individual report problems (historical or current) with any of the following?

- Illegal drug Prescription drug Non-prescription (OTC) Alcohol Gambling Tobacco None Reported

Was any evidenced-based screening tool(s) used?: No Yes - If Yes, specify:

If yes to any, and required for OASAS, complete Substance Use/Addictive Behavior Assessment. (OASAS Programs must also have individual complete Communicable Disease Risk Assessment)

Mental Health Treatment History

Addiction Treatment Service History

Treatment Services History Within the Past 5 years None Reported

Type of Services	Dates of Service	Reason	Name of Provider/Agency:	Completed
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes
	/			<input type="checkbox"/> No <input type="checkbox"/> Yes

Comment further if additional episodes, as indicated:

What was helpful with past treatment?

What was not helpful?

Additional Comments:



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OASAS ONLY	Number of prior substance /alcohol abuse treatment episodes, lifetime (Enter 0 – 5):	
	Has the individual ever been diagnosed with Mental Retardation/Developmental Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Co-existing Psychiatric disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Ever Treated for a mental illness problem	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Ever Hospitalized for mental illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Ever Hospitalized for 30 or more days for mental illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
	Six Months Prior to Admission: Number Days in Inpatient Detox: _____ Number of Emergency Room Episodes: _____ Number of Days Hospitalized for Non-Detox Services: _____ Reason for Hospitalization: <input type="checkbox"/> Medical <input type="checkbox"/> Psychiatric <input type="checkbox"/> Both	
	Brief Mental Health Screening	
Was any evidenced-based screening tool(s) for mental health used?: <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, specify:		
Describe results:		
Based on tool(s) and/or psychiatric information, Mental Health Screening indicates immediate mental health services needed. <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, specify needs:		

Past and Current Social and Developmental Status:

Developmental History (Include individual and family history, motor development and functioning, sensory, speech, hearing and language problems):

Sexual History

Sexual History/Concerns (Include sexual orientation and other relevant information; OMH complete Communicable Disease Assessment as indicated): NA – Based upon the Individual's age and needs

Vocation/Education/Employment

Highest Grade Completed <input type="checkbox"/> No formal education <input type="checkbox"/> Pre-K <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th	<input type="checkbox"/> 5th <input type="checkbox"/> 6th <input type="checkbox"/> 7th <input type="checkbox"/> 8th <input type="checkbox"/> 9th <input type="checkbox"/> 10th <input type="checkbox"/> 11th <input type="checkbox"/> 12th, no diploma (OMH Only)	<input type="checkbox"/> High School Diploma <input type="checkbox"/> General Equivalency Diploma <input type="checkbox"/> Vocational Cert w/o Diploma/GED <input type="checkbox"/> Vocational Cert w/ Diploma/GED <input type="checkbox"/> Some College – No degree <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Graduate Degree
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OASAS Only	Employment Status (Check One)		
	<input type="checkbox"/> Employed FullTime-35+ hrs/wk	<input type="checkbox"/> Not in Labor Force, Disabled	<input type="checkbox"/> Soc Svcs Work Exp Program
	<input type="checkbox"/> Employed Part Time-<35 hrs/wk	<input type="checkbox"/> Not in Labor Force, In Training	<input type="checkbox"/> Soc Svcs Determined, Not Employed/Able to Work
	<input type="checkbox"/> Employed in Sheltered Workshop	<input type="checkbox"/> Not in Labor Force, Inmate	<input type="checkbox"/> Soc Svcs Determined, Unable to Work, Mandated Treatment
	<input type="checkbox"/> Unemployed, In Treatment	<input type="checkbox"/> Not in Labor Force, Retired	
	<input type="checkbox"/> Unemployed, Looking for Work	<input type="checkbox"/> Not in Labor Force, Student	
	<input type="checkbox"/> Unemployed, Not Looking for Work	<input type="checkbox"/> Not in Labor Force, Other	
	<input type="checkbox"/> Not in Labor Force, Child Care		



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OMH Only	Employment Status (Select First that applies)	
	<input type="checkbox"/> Competitive and integrated employment <input type="checkbox"/> Other Employment <input type="checkbox"/> Non-paid work position (volunteer)	<input type="checkbox"/> Unemployed and looking for work <input type="checkbox"/> Not in Labor Force: unemployed but not looking for work, retired, homemaker, student, incarcerated or psychiatric inpatient

Employment History NA

Type of Job	How Long	Reason for Leaving
	____ Months / ____ Years	
	____ Months / ____ Years	
	____ Months / ____ Years	
	____ Months / ____ Years	

Approximate Literacy Level (Required for OASAS/CARF-see Manual) and impact on treatment, if any:

Children and Adolescents

Name of School:	Current Grade:
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Regular Education Classroom (No Special Services): No Yes - If no, check all that apply below.

Educational Classification		
<input type="checkbox"/> Autism <input type="checkbox"/> Deafness <input type="checkbox"/> Deaf-Blindness <input type="checkbox"/> Emotional Disturbance <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Learning disability	<input type="checkbox"/> Multiple disabilities <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Other Health Impairment <input type="checkbox"/> Speech or language Impairment <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Visual Impairment	Additional Information, if indicated: Current IEP: <input type="checkbox"/> No <input type="checkbox"/> Yes Current 504 Plan: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Home Schooled <input type="checkbox"/> Gifted

Comments on Past and Current Academic Functioning (include grades, learning ability, learning style and any other relevant indicators):

Test or Other Evaluation Results (IQ; achievement; developmental; PT/OT; etc.) No Test Results Reported -

Attendance: Not a Problem -

Previous Grade Retentions: Denied -

Suspensions/Expulsions: Denied -

Additional Barriers to Learning:

Peer Relationship/Social Functioning:



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Vocation/Education/Employment Screen/Summary (For Children/Adolescents and Adults)

Does the individual want help with or desire further discussion of the following? If yes to any area below, comment on history, strengths, weaknesses and aspirations (required for OASAS/COA):

Vocational No Yes Comment:

Educational No Yes Comment:

Employment No Yes Comment:

Military Service Screen

Has the individual ever served in the military? No Yes - If Yes, Comment:

If yes, is the individual currently experiencing:

Physical health concerns as a result of military experience?

Pain right now or have experienced chronic pain? Frequent nausea, stomach upset, and/or deliriums?

Concerns of possible infectious agents, toxins, or radiological exposure?

Psychological Issues related to military service (Flashbacks, Nightmares, etc.)

Individual has concerns that seeking help may impact his/her career.

Comments:

Further assessment with the Military Service Assessment can be done *at any point during care.*

Is there someone in the family, or a significant other, in the military? No Yes - If Yes, Comment:

If yes, further assessment with the Military Service Assessment for Significant Others can be done *at any point during care.*

LEGAL INVOLVEMENT HISTORY None Reported

Does the individual have a history of, or current, involvement with the legal system (i.e., legal charges, AOT, Specialized Courts-Drug, Mental Health, Family, Arrests, Incarceration, etc.)? No Yes

Is there a family history of, or current involvement with CPS? No Yes / APS? No Yes

If yes to either of the above, complete and attach the Legal Involvement and History Addendum.

Legal Status

Does Individual Served have a Legal Guardian, Rep Payee or Conservatorship? No Yes

If Child, is there a Special Needs Trust other than parent? No Yes

If yes to either question above, complete and attach the Legal Status Addendum

Is there a need for a Legal Guardian, Rep Payee, Conservatorship or Special Needs trust? No Yes

If yes, explain:

Does the individual have any advance directives? No Yes

If yes, what type? DNR Health Care Proxy Living Will Psychiatric Advance Directive



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Living Situation (Reference Personal Information Form)

Household composition and any housing needs:

Family History and Relationships

Comment on family/significant other relationships as applicable (Describe past and current relationships with family/significant others):

Family History of Relevant Health (including Developmental Disabilities), Mental Health, and Addiction concerns:

Custody Issues: NA OR:

Describe custody arrangement/parenting plan as it relates to individual/comments:

OASAS Only	<p>Is the individual a Child of a person with Alcoholism and/or a Child of a person with a Substance Abuse Disorder?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Both <input type="checkbox"/> Child of a person with Alcoholism <input type="checkbox"/> Child of a person with a Substance Abuse Disorder</p>
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Trauma History

Does individual report a history, or current experience, of:

Select all that are reported:

Physical Abuse/Neglect Elder Abuse Community Violence Verbal/Emotional Abuse Sexual Abuse/Molestation

Immigration Trauma Witness to Violence Domestic Violence

Other:

None Reported

Provide Relevant Details and Current Clinical Impact:

Social/Leisure Supports/Concerns

Friendships/Social/Pets/Peer Support Relationships:

Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other daily activities):

Community Supports/Self Help Groups (AA, NA, NAMI, Double Trouble, Peer Support, Meals-on-Wheels, etc.):

(OASAS) Has the Individual attended 12 step or other self-help groups in the last 30 days? No Yes



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Religion/Spirituality (Discuss protective and/or risk aspects):

Cultural/Ethnic Information (Discuss protective or risk aspects):

OASAS & ACT	Assessment of daily living / community living skills and ability for self care (include strengths and weaknesses):
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Physical Health History

Refer to Brief Medical Screening Form (includes past and current Medication information) dated:

Additional Comments, if indicated:

Mental Status, Suicide and Violence Risk

Suicide and Self-Harm Screen/Assessment

Sources of Information

<input type="checkbox"/> Columbia-Suicide Severity Rating Scale (C-SSRS)	<input type="checkbox"/> Clinical Interview	<input type="checkbox"/> Clinical records
<input type="checkbox"/> Other approach or evidence based tool (i.e. Chronological Assessment of Suicide Events (CASE) Approach – If yes, specify:	<input type="checkbox"/> Collateral sources	

Suicidal ideation (history/current): No Yes – If Yes, provide details:

Suicidal planning (history/current): No Yes - If Yes, provide details:

History of suicidal behaviors? No Yes - If Yes, provide details:

History of self-injurious behavior (i.e. cutting, burning)? No Yes - If Yes, provide details and note safety management plan below:

Is there evidence of suicide risk? No Yes – If Yes:

Does the individual have access to lethal means/weapons? No Yes - If Yes, provide details:

Describe discussion with individual/family to secure access to lethal means/weapons.



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Identify and discuss impact of significant risk and protective/mitigating factors:

Safety Management Plan: Describe in detail how elements of risk will be managed, including any risk for non-suicidal self-injurious behavior:

Violence Screen

Sources of Information

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Other approach or evidence based tool (i.e. Chronological Assessment of Suicide Events (CASE)
Approach – If yes, specify:
- Clinical Interview
- Collateral sources
- Clinical records

Recent thought/intention or actual plan to hurt others? No Yes - If Yes, provide details:

History of threatening/attempting or actually hurting others? No Yes - If Yes, provide details:

Current and/or recent thoughts or behaviors that others might interpret as threatening? No Yes - If Yes, provide details:

Other areas of concern including those from previous sections? No Yes - If Yes, note below as relevant to risk factors.

Is there evidence of violence risk? No Yes - If Yes:

Does the individual have access to lethal means/weapons? No Yes – If Yes, provide details:

Describe discussion with individual/family to secure access to lethal means/weapons.

Identify and discuss impact of significant risk and protective/mitigating factors:

Safety Management Plan: Describe in detail how elements of risk will be managed and/or how continued assessment will be conducted:



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Mental Status Evaluation (Narrative Below) OR Refer to MENTAL STATUS ADDENDUM (Recommended for OASAS)

Mental Status Evaluation Date Conducted:
 (Provide a thorough written narrative below covering the following areas: Appearance and Behavior; Mood and Affect; Speech; Thought Process; Thought Content; Suicidal/Homicidal ideation; Cognition (if impaired, do Folstein Mini-Mental Status Exam), Insight and Judgment):

Life Goals, Strengths, Abilities, and Barriers

Life Goals:

Strengths (skills, talents, interests, protective factors):

Barriers (environmental and personal):

Past and Present Successes in Achieving Desired Goals:

Service Preferences: describe individual/family/guardian/significant other perception of needs and preferences for health care and behavioral health services, including family participation in care and environmental supports (self-help, advocacy and empowerment activities):

For OMH IPRT Only

Rehabilitation aspirations and results of the Psychiatric Rehabilitation Readiness Determination Form, including score:

For OMH Part 599 (Clinic) and Part 587.11 (Children's Day Treatment)
 List collaterals interviewed:

Clinical Formulation – Interpretative Summary

Interpretive Summary: What in your clinical judgment are the need areas, the factors that led to the needs, and the skills and resources needed to address them? Comment on desire and motivation to learn, and ability/capacity to respond to treatment. Base summary on full Comprehensive Assessment which includes Personal Information Form and additional assessments/addendums completed (i.e. Brief Medical Screening; Communicable Disease; Substance Abuse; Legal, etc.):



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Diagnosis: DSM Codes ICD Codes

Check Primary	Axis	Code	Narrative Description
<input type="checkbox"/>	Axis I		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>	Axis II		
<input type="checkbox"/>			
<input type="checkbox"/>	Axis III		
<input type="checkbox"/>			
<input type="checkbox"/>			
	Axis IV	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with primary support group: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems related to the social environment: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Educational problems: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Occupational problems: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Housing problems: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Economic problems: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with access to health care services: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with interaction with the legal system/crime: If yes, describe:
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Other psychosocial and environmental problems: If yes, describe:
Axis V	Current GAF:	Highest GAF in Past Year (if known):	

Further Evaluations Needed:

None Indicated
 Psychiatric
 Psychological
 Neurological
 Medical
 Educational
 Employment
 Visual
 Auditory
 Nutritional
 Other:

Prioritized Assessed Needs: <i>OASAS providers must provide clinical conclusions on each of the Eight Functional Areas: 1 Chemical dependence/abuse; 2 Physical health; 3 Mental health; 4 Vocational/educational/employment; 5 Social/leisure; 6 Family, 7 Legal; 8 Problem Gambling</i>	A-Active, IFD-Individual or Family/Guardian Declined, D-Deferred, N/A-Not Applicable, R-Referred Out				
	A	IFD*	D*	NA*	R*
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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4.				<input type="checkbox"/>						
5.				<input type="checkbox"/>						
6.				<input type="checkbox"/>						
7.				<input type="checkbox"/>						
8.				<input type="checkbox"/>						
9.				<input type="checkbox"/>						
<p>*Individual Declined/Deferred/Referred Out-Rationale(s) (Explain why the Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out/NA; Offer time frame for deferment below). <input type="checkbox"/> None</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p> <p>7.</p> <p>8.</p>										
<p>OMH Disposition (Applicable for First Assessment Session):</p> <p><input type="checkbox"/> Continue Assessment</p> <p><input type="checkbox"/> Admit (If admitting today, use this as Admission Note; otherwise use appropriate Progress Note upon Date of Admission):</p> <p>If continuing assessment or admitting describe Initial Plan for Services (If admitting today, provider may skip this section and initiate services by completing at least one goal with one objective on the IAP):</p> <p><input type="checkbox"/> Do Not Admit (Provide rationale and referrals made)</p> <p><input type="checkbox"/> Individual declined services:</p> <p><input type="checkbox"/> Other:</p>										
<p>Individual Served/Guardian/Family Response to Recommendations (if family did not participate explain why):</p>										

