





<b>Organization Name:</b>		<b>Program Name:</b>		<b>Date:</b>
<b>Individual's Name (First MI Last):</b>			<b>Record #:</b>	<b>DOB:</b>
<input type="checkbox"/>				
<input type="checkbox"/>	Axis II			
<input type="checkbox"/>				
	Axis III			
	Axis IV	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:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Axis V	Current GAF:	Highest GAF in Past Year (if known):		

<b>Prioritized Assessed Needs:</b> <input type="checkbox"/> No Additional Recommendations Clinically Indicated					
A-Active, ID-Individual Declined, D-Deferred, F/G-Family/Guardian declined, R-Referred Out (If declined/deferred/referred out, please provide rationale)					
	A	ID*	FG*	D*	R*
1.	<input type="checkbox"/>				
2.	<input type="checkbox"/>				
3.	<input type="checkbox"/>				
4.	<input type="checkbox"/>				

**\*Individual Declined/Deferred/Referred Rationale(s)** (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred or Referred Out below).  None

1.



<b>Organization Name:</b>	<b>Program Name:</b>	<b>Date:</b>
<b>Individual's Name (First MI Last):</b>	<b>Record #:</b>	<b>DOB:</b>
2.		
3.		
<b>Individual's Signature (Optional):</b>	<b>Date:</b>	
<b>Guardian's Signature (Optional):</b>	<b>Date:</b>	
<b>Physician/NPP - Print Name/Credentials:</b>	<b>Physician/NPP Signature:</b>	<b>Date:</b>
<b>Supervisor - Print Name/Credentials (if applicable):</b>	<b>Supervisor Signature (if applicable):</b>	<b>Date:</b>