Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:
Admission Date:	**Service Plan Due:**	

Service Related Needs (Reason for Admission):

Individual Strengths (Required for C & A):

Alerts: Check all current risk factors that apply. Provide details, as indicated, in the Comments Section:

- ☐ **Allergies**
- ☐ **Danger to Others**
- ☐ **Danger to Self**
- ☐ **Substance Use or Abuse**
- ☐ **Medical Conditions/Problems**
- ☐ **Medication Side Effects**
- ☐ **Needle Disposal Issue (e.g., Diabetes)**
- ☐ **Physical / Sexual Abuse or Neglect** (☐ **Survived** ☐ **Perpetrated)**
- ☐ **Other:**

Comments:

Diagnosis: ☐ DSM Codes ☐ ICD Codes

Check Primary	**Axis**	**Code**	**Narrative Description**
☐	Axis I		
☐			
☐			
☐	Axis II		
☐			
	Axis III		
	Axis IV		
	Current GAF:		Highest GAF in Past Year (if known):

Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:
Admission Date:	**Service Plan Due:**	

Initial services
Indicate the Community Rehabilitation Service(s) staff will provide to meet the individual's identified needs during the initial period after admission.

Adult Services	
☐ Assertiveness/Self-Advocacy training	☐ Rehabilitation Counseling
☐ Community Integration/Resource Development	☐ Skill Development Service
☐ Daily Living Skills Training	☐ Socialization
☐ Health Service	☐ Substance Abuse Services
☐ Medication Management Training	☐ Symptom Management
☐ Parenting Training	☐ Other:

Children and Adolescent Services	
☐ Behavior Support	☐ Independent Living Skills Training
☐ Case Management	☐ Medication Management
☐ Counseling Services	☐ Medication Monitoring
☐ Daily Living Skills Training	☐ Respite
☐ Educational-Vocational Support Services	☐ Socialization
☐ Family Support Services	☐ Other:
☐ Health Services	☐ Other:

Additional Comments, if indicated:

Individual's Signature (if indicated):		Date:
Guardian's Signature (if indicated):		Date:
Completed By - Print Staff Name/Credentials: ☐ QMHS	**Staff Signature:**	Date:
Supervisor – Print Name/Credentials (if applicable**):**	**Supervisor Signature:**	Date: