

COMMUNITY CARE BEHAVIORAL HEALTH

PRE-INTAKE SCREENING FORM

(To accompany Intake Form)

Client's Name: _____ Date: _____

Client Address _____ Cell #: _____

City: _____ State: _____ Zip Code: _____ House #: _____

DOB _____ Age: _____ S.S.# _____ Medicaid #: _____

Referral Source/ Title: _____ Tele.: _____

Agency: _____ Fax: _____

Address: _____

Residence Contact Person(s): _____ Tele: _____ Cell #: _____

Presenting Problem/Reason for Referral: _____

Date of Most Recent Psychiatric Hospitalization: _____ Name of Hosp: _____

Provisional Diagnosis: (See Intake for Final Diagnosis)

AXIS I: _____

AXIS II: _____

AXIS III: _____

Primary Physician: _____ Tele: _____

Primary Psychiatrist: _____ Tele: _____

Transfer to program psychiatrist: Y ___ N ___ (If yes, please √ if former psychiatrist sent clinic letter w/date _____)

Pharmacy: _____ Tele: _____

Mental Health providers currently utilized, please √ Case Manager ___ Social Worker ___ Psychiatrist ___ Therapist ___ Other ___

Agency: _____ Contact: _____ Tele: _____

Other Services providers currently utilized and types of services: _____

Agency: _____ Contact: _____ Tele: _____

Agency: _____ Contact: _____ Tele: _____

Medicaid status pending approval by: Med. Needy/ NJ Care Medicare #: _____ Other: _____

Intake Appointment Date: _____ Time: _____ Intake Completed On: _____ Scheduled start date: _____

Probat. Per.: _____ Completed: Y N Reason: _____ Last Day Attended: _____

Program Schedule: _____ Program Criteria Met: Yes No Unsure

Intake Worker's Signature: _____ Title: _____ Date: _____

MEDICAL/ MEDICATIONS INFORMATION SHEET *(Part of Psychiatrist's Initial Psychiatric Evaluation)*

I. MEDICAL

A. HISTORICAL

Please record accidents, surgeries, medical conditions, dates of hospitalizations, etc. If client denies same or if information is unavailable at point of referral, please check N/A ___; & date information in the intake when available.

B. LEGAL

Legal involvement: Y ___ N ___ Probation: Y ___ N ___ Parole: Y ___ N ___ Describe: _____

Outstanding Warrants: Y ___ N ___ Describe: _____

C. CURRENT

Allergies: _____

Medical Risk Factors: Y ___ N ___ Please describe: _____

Protocols to follow: _____

Chronic Physical Condition(s): _____

Medical Specialist: _____ Tele: _____

Medical Specialist: _____ Tele: _____

D. CURRENT MEDICATION REGIMEN

For **past** medication history, please refer to Initial Psychiatric Evaluation.

Please list all medications, psychotropic and medical, which comprise client's **current** medication regimen.

- | | | | |
|-----------------------|---------------|-----------------|-------------|
| 1. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 2. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 3. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 4. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 5. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 6. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 7. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 8. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 9. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 10. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 11. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 12. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |
| 13. Medication: _____ | Dosage: _____ | Schedule: _____ | Noon: _____ |

I have read and reviewed the above information.

PSYCHIATRIST'S SIGNATURE: _____ **DATE:** _____