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| ESP Name: | | | | | | | | | | | ESP Phone: | | | | | | | | | | | | | |
| Location of Service: | | | | | | | | | | | Date: | | | | | | | | | | | Time: | | |
| Referral Source: | | | | | | | | | | | Referral Phone: | | | | | | | | | | | | | |
| **Demographics** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | | | | | | | | | |
| Gender: | | | | | | | | | | | Marital status: | | | | | | | | | | | | | |
| Street Address: | | | | | | | | | | | | | | | | | | | | | | | | |
| City, State, Zip: | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | Living Situation: | | | | | | | | | | | | Homeless:  Yes  No | | |
| Emergency Contact (name, relation, phone): | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Language: | | | | | | | | | | | Interpreter used:  Yes  No; if **yes**, explain: | | | | | | | | | | | | | |
| **Presenting Concerns** | | | | | | | | | | | | | | | | | | | | | | | | |
| Presenting Problem: | | | | | | | | | | | | | | | | | | | | | | | | |
| Precipitating Factors: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Legal** | | | | | | | | | | | | | | | | | | | | | | | | |
| Legal guardian:  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Rogers guardian:  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Healthcare proxy:  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the person have involvement in the legal system (i.e. legal charges, parole / probation, registered sex offender, other)? *specify if current or historical* :  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Collaterals** | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Type*** | | | | ***Name*** | | | | | | | | | ***Telephone*** | | | | ***Contacted*** | | | | | ***Agency*** | | |
| PCC / PCP | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| Clinician | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| Psychiatric Prescriber | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| DMH | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| DDS | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| DCF | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| DYS | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| School / Residential | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| Family / Sig. Other | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| Other | | | |  | | | | | | | | |  | | | | Y  N  LM | | | | |  | | |
| Comments: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical / Physical** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please note any special medical considerations (i.e. recent medical admissions, pregnancy, diabetes, sleep apnea, catheters, O2, dialysis, sutures, open wounds, seizures, infectious diseases, other): | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical equipment needed (i.e. CPAP, wheelchair, other):  Yes  No; if **yes**, does the person have equipment? Explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Can person ambulate without assistance?  Yes  No; if **no**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Can person perform ADLs independently?  Yes  No; if **no**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies reported (food, medications, other):  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| (If Opioid overdose) Immunodeficiency virus, Hep C, and Tuberculosis **RISK**: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications** | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Medication*** | | | | | | | | ***Dosage*** | | | | | ***Frequency*** | | ***Route*** | | | | | | | ***Prescriber*** | | |
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| Comments on medications (past or present): | | | | | | | | | | | | | | | | | | | | | | | | |
| **Relevant History** | | | | | | | | | | | | | | | | | | | | | | | | |
| Family History (past or present): | | | | | | | | | | | | | | | | | | | | | | | | |
| Trauma History: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Addiction** | | | | | | | | | | | | | | | | | | | | | | | | |
| Current use of substances and / or addiction?  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Was a toxicology screen performed?  Yes  No; if **yes**, results: | | | | | | | | | | | | | | | | | | | | | | | | |
| Was Narcan administered in the past 30 days?  Yes  No; if **yes**, explain (include date / time): | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Substance / Type*** | | | | | | ***First use / Age of Onset*** | | | | | | | ***Last Use*** | ***Quantities*** | | | | | ***Duration / Frequency*** | | | | ***Comments*** | |
| Alcohol | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Cannabis | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Cocaine / Crack | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Heroin | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Opiates / Narcotics | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Benzodiazepines | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Stimulants | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Hallucinogens | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Prescription | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Other (i.e. food, sex, gambling, tobacco, etc.): | | | | | |  | | | | | | |  |  | | | | |  | | | |  | |
| Additional Information (may include non-current history and must include consequences of use in case of opioid overdose): | | | | | | | | | | | | | | | | | | | | | | | | |
| **Most Recent Acute Admission(s) and Treatment History**  *(Inpatient, Detox, CCS, EATs, PHP, Outpatient, other)* | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Dates of Service*** | | | | ***Type of Service*** | | | | | | | | ***Provider*** | | | | | | | | ***Response to Treatment*** | | | | |
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| Comments: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mental Status Exam / Risk Assessment**  *(within normal limits unless checked, items checked are addressed in clinical formulation / narrative)* | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Appearance | | | | |  | | | Memory | | | | | | | | |  | | Weight Change | | | |
|  | | Eye Contact | | | | |  | | | Insight | | | | | | | | |  | | Energy | | | |
|  | | Speech | | | | |  | | | Judgment | | | | | | | | |  | | Future Oriented | | | |
|  | | Sleep | | | | |  | | | Impulsivity | | | | | | | | |  | | Concentration | | | |
|  | | *\*Harm to Self* | | | | |  | | | Mood | | | | | | | | |  | | Appetite | | | |
|  | | *\*Harm to Others* | | | | |  | | | Affect | | | | | | | | |  | | Thought Content | | | |
|  | | Perception: Delusions, Hallucinations | | | | |  | | | Orientation: person, time, place, situation | | | | | | | | |  | | Cognitive Functioning: Intellectual Disability, other | | | |
|  | | Elopement | | | | |  | | | Sexualized Behavior | | | | | | | | |  | | Fire Setting | | | |
| *\*Harm to Self and Others include: means, accessibility (including access to firearms), lethality of means,*  *suicidal / assault history, lethality of attempts / assaults, family history, self-injurious behavior* | | | | | | | | | | | | | | | | | | | | | | | | |
| **Risk and Protective Factors** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Strengths and Service Preferences** | | | | | | | | | | | | | | | | | | | | | | | | |
| Person’s strengths and service preferences: | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there a Safety Plan?  Yes  No; if **yes**, explain or attach: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Clinical Formulation / Narrative / Medical Necessity for Further Treatment** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosis** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | ***Code*** | | ***Diagnosis*** | | | | | | | | | | | | | | | | | | | |
| Primary | | |  | |  | | | | | | | | | | | | | | | | | | | |
| Secondary | | |  | |  | | | | | | | | | | | | | | | | | | | |
| Other | | |  | |  | | | | | | | | | | | | | | | | | | | |
| Other | | |  | |  | | | | | | | | | | | | | | | | | | | |
| **Identified Needs and Goals for Treatment** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Resolution / Disposition / Treatment Recommendations**  *(check all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Inpatient Psychiatric | | | | |  | | | CCS Unit | | | | | | |  | | Narcotic Treatment Services | | | | | | |
|  | Outpatient MH / SA | | | | |  | | | ESP Follow-up Visit | | | | | | |  | | Pregnancy Enhanced SA Services | | | | | | |
|  | Obs. / Intensive Obs. | | | | |  | | | Med Management Visit | | | | | | |  | | Urgent Outpatient | | | | | | |
|  | Medical Admission | | | | |  | | | Level IV Detox | | | | | | |  | | Self-help / Peer | | | | | | |
|  | Partial Hospitalization | | | | |  | | | EATS (DDART) | | | | | | |  | | Returned to Police / Court | | | | | | |
|  | Day Treatment | | | | |  | | | SOAP | | | | | | |  | | Refused / Declined Treatment | | | | | | |
|  | CSP | | | | |  | | | ATS | | | | | | |  | | | | | | | | |
|  | Other (i.e. DDAT, IOP) describe: | | | | | | | | | | | | | | | | | | | | | | | |
| **If Applicable** | | | | | | | | | | | | | | | | | | | | | | | | |
| Next Appointment (date, time, location): | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider: | | | | | | | | | | | | | | | | | | | | | | | | |
| Accepting Facility: | | | | | | | | | | | | | | Accepting Doctor: | | | | | | | | | | |
| Transported by: | | | | | | | | | | | | | | | | | | | | | | | | |
| Medications administered:  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Restraints used:  Yes  No; if **yes**, explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical clearance provided by: | | | | | | | | | | | | | | Psychiatric consult with: | | | | | | | | | | |
| **Insurance Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance: | | | | | | | | | | | | | Policy number: | | | | | | | | | | | |
| Authorization number: | | | | | | | | | | | | | Number of days: | | | | | | Next review date: | | | | | |
| Person Authorizing: | | | | | | | | | | | | | Phone number: | | | | | | | | | | | |
| Secondary Insurance: | | | | | | | | | | | | | Policy number: | | | | | | | | | | | |
| Authorization number: | | | | | | | | | | | | | Number of days: | | | | | | Next review date: | | | | | |
| Person Authorizing: | | | | | | | | | | | | | Phone number: | | | | | | | | | | | |
| Comments (i.e. subscriber): | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signatures** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | ***Name*** | | | | | | | | | | | | | | | ***Date*** |
| ESP Clinician (print name / credentials: | | | | | | | | |  | | | | | | | | | | | | | | |  |
| ESP Clinician Signature: | | | | | | | | |  | | | | | | | | | | | | | | |  |
| Consulted with (print, if applicable): | | | | | | | | |  | | | | | | | | | | | | | | |  |
| Other (print, if applicable): | | | | | | | | |  | | | | | | | | | | | | | | |  |
| Other signature: | | | | | | | | |  | | | | | | | | | | | | | | |  |