

# Western Highlands Access - Screening Form

FAX # 828-225-2782

Please make sure the demographic and insurance information is complete. Requests cannot be processed without this information and the clinical data.

Last Name	First Name	Middle Initial	Maiden Name	
<b>Client:</b> _____				<b>Date of consumer's call:</b> _____ <b>Time of consumer's call:</b> _____ <b>Date of screening:</b> _____ <b>Time of screening:</b> _____
<b>Address:</b> _____				
			City	State
			Zip	
<b>Phone:</b> (Home) _____		(Work or Cell) _____		<b>Type of Contact:</b> Telephone    Face-to-face
<b>Marital Status:</b> S M Sep D W			<b>Referral Source:</b> Person, Agency, Address and Phone: _____	
<b>Social Security #</b> _____			<b>Tobacco Use:</b> Yes No <b>Substance abuse:</b> Yes No	
<b>Guardian:</b> _____			<b>Employment Status:</b> _____	
<b>Age:</b> _____		<b>Birthdate:</b> _____		<b>Sex:</b> M F
<b>Veteran:</b> Yes No		<b>Highest grade completed:</b> _____		<b>Insurance:</b> N Y <b>Type:</b> _____
<b>Race:</b> _____		<b>Ethnicity:</b> _____		<b>Previous WHLME Contact:</b> Yes No <b>Case #</b> _____
<b>English Proficient?</b> Yes No <b>if No, what language is primary:</b> _____				

**Chief Complaint:**

**Presenting Problems** (circle):

As reported by: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Danger To Self:** None. Thoughts of suicide, Threats of suicide, Thoughts of death, Suicide attempt, Inability to care for self, Self harming behavior.  
 When? \_\_\_\_\_ Plan? \_\_\_\_\_

**Past Danger to Self:** None. Thoughts of suicide, Suicidal gestures, Suicide attempts, Family history of suicide. Inability to care for self.  
 When? \_\_\_\_\_ Method? \_\_\_\_\_

**Danger to Others:** None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others, Inability to care for others. When? \_\_\_\_\_ Plan? \_\_\_\_\_

**Past Danger to Others:** None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others, Inability to care for others. When? \_\_\_\_\_ Plan? \_\_\_\_\_

**Hospitalizations:** Mental Health: Total admissions \_\_\_\_\_ Hospitalizations in the last 2 years? \_\_\_\_\_

SA Facilities: Total admissions \_\_\_\_\_ SA admissions in the last 2 years? \_\_\_\_\_

Seasonal Patterns? No Yes describe \_\_\_\_\_

**Relationship Issues:** None. Conflict with peers, siblings, parents, spouse, significant other, children. No/Few friends. Running away from home, Family desertion, Separation, Divorce, Visitation or custody disputes, Child neglect, Child abuse, Spouse abuse.  
 (If Abuse, specify \_\_\_\_\_.) Death in family, No significant relationships, Other \_\_\_\_\_

**Medical Problems:** None. Disabled, Hearing impaired, Recent illness, HIV, Hep C, Diabetes, Pregnant, Surgery, Other \_\_\_\_\_  
 Physician \_\_\_\_\_ Pharmacy \_\_\_\_\_ Number \_\_\_\_\_

**Current Medications:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Substance Use/Abuse:** Current Abuse: Alcohol N Y describe \_\_\_\_\_  
 Amphetamines N Y describe \_\_\_\_\_  
 Benzodiazepines N Y describe \_\_\_\_\_  
 Narcotics N Y describe \_\_\_\_\_  
 Cocaine/Crack N Y describe \_\_\_\_\_  
 Marijuana N Y describe \_\_\_\_\_  
 Hallucinogens/Inhalants describe \_\_\_\_\_

Assess need for detoxification if client is currently impaired/intoxicated Current pattern of use (what and how much): \_\_\_\_\_  
 Date of last use \_\_\_\_\_

Alcohol Level? Date \_\_\_\_\_ Time \_\_\_\_\_ Method \_\_\_\_\_ Result \_\_\_\_\_

Current withdrawal symptoms (circle): None, Vomiting, Sweating, Agitation, Tactile disturbances, Auditory disturbances, Visual disturbances, Headache, Tremors/Shakes    **If any symptoms exist, fill out the Medical Detoxification Screening Form**

Name: \_\_\_\_\_

Has Abused: Narcotics, Amphetamines, Hallucinogens, Inhalants, Marijuana, Cocaine, Crack, Alcohol, Benzodiazepines, Pain killers, Other \_\_\_\_\_ Hospitalizations, Family problems, Job loss, Abuse related arrests, Other \_\_\_\_\_  
Past withdrawal symptoms: DT's Blackouts Other \_\_\_\_\_

**Depressive Symptoms:** None. Sadness, Fatigue, Increased/Decreased Sleep, Increased/Decreased Appetite, Hopelessness, Loss of interest, Feelings of worthlessness, Guilt, Agitation, Poor concentration, Crying, Anger, Social isolation, Irritability, Other \_\_\_\_\_

**Anxiety:** None. Anxiety, Conversion, Obsessions, Compulsions, Phobia, Multiple operations, Multiple somatic complaints, Nightmares, Panic attacks, Separation anxiety, Soiling, Other \_\_\_\_\_

**Manic-Like Behavior:** None. Euphoria, Over-talkative, Sleep Loss, Grandiosity, Extravagance, Racing Thoughts, Other \_\_\_\_\_

**Developmental Disabilities:** None. TBI/ Head injury, Autism spectrum, Ambulatory, Verbal, Needs assistance with independent living skills, Needs assistance with ADL's, Borderline intelligence, Mental retardation/mild/moderate/severe. Other \_\_\_\_\_

**Psychotic/Organic Symptoms:** None. Unmanageable, Inability to care for self, Memory deficits, Withdrawn, Wanders off, Poor personal hygiene, Does not make sense, Suspiciousness, Sleep loss, Poor judgment, Forgetfulness, Confusion, Auditory hallucinations, Visual hallucinations, Delusions, Disorientation, Other \_\_\_\_\_

**Antisocial:** None. Frequent lying, Stealing, Excessive fighting, Destroys property, Fire setting, Arrests, Convictions, Imprisoned, Sexually inappropriate, Exhibitionism, Uses assumed names, Acts alone in peer group, Probation, Parole, Pending charges, Physically cruel to animals, Other \_\_\_\_\_

**Education Difficulties:** None. Behavior problems, Academic problems, Needs/receives special education, Needs technical training, Truancy, Drop out, Suspensions, Expulsion, Other \_\_\_\_\_

**ADD or ODD:** None. Hyperactivity, Impulse control, Attention span, Loses temper, Argumentative, Annoys others, Blames others, Other \_\_\_\_\_

**Other Information:** Homeless, Lives at shelter (which one?) \_\_\_\_\_ Lives with family/friends (Who?) \_\_\_\_\_  
Phone # \_\_\_\_\_ Would you like someone to contact you about affordable housing information? \_\_\_\_\_  
Financial Stress, Unemployed, Receives disability income, Cannot afford medications, Transportation problems.

**Summary/Comments:** \_\_\_\_\_  
\_\_\_\_\_

**Urgency Designation, circle:** Emergent (assess face to face within 2 hr.)    Urgent (assess face to face within 48 hr.)    Routine (assess face to face within 7 days)

**Time of Day "Urgency Designation" was determined:** \_\_\_\_\_

**Consumer Choice:** Has this consumer been offered a choice of providers? Yes No  
Choices offered and reasons for choice are documented in: Admission assessment, Chart, Other \_\_\_\_\_

**Tentative Diagnosis:** \_\_\_\_\_

**Disposition:** Client to walk in and see \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_

Client seen and given an appointment to return for \_\_\_\_\_ at \_\_\_\_\_

Client referred to another provider: Provider Name: \_\_\_\_\_ Appointment date and time \_\_\_\_\_

**Service Authorization Request:** (You must indicate at least one and fill in the effective date)

Community Support (State Funds) – 24 Units Effective Date \_\_\_\_\_  Diagnostic Assessment – 1 Event Effective Date \_\_\_\_\_

Community Support (Medicaid) – 36 Units Effective Date \_\_\_\_\_  H0001- SA Assessment – 8 units Effective Date \_\_\_\_\_

H0031 – MH Assessment -8 units AND H0004 – Individual – 12 units Effective Date \_\_\_\_\_

T1017HI: DD Case Management/State– 40 units Effective Date \_\_\_\_\_ (case management must be in PCP)

T1017HI: DD Case Management/Medicaid – 60 units Effective Date \_\_\_\_\_ (case management must be in PCP)

**Other:** \_\_\_\_\_ Units \_\_\_\_\_ Effective Date \_\_\_\_\_

**Clinician name (please print):** \_\_\_\_\_ **Signature and credentials:** \_\_\_\_\_

**Agency:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

**LME Access use only - Case Number Assigned:** \_\_\_\_\_