Adult Pre-Evaluation Screening

Date: Time In: Time Out:	Interview Location:
Individuals Present:	
Interpretative Aids/Assisted Devices:	Pending Felony Charges: ☐ Yes ☐ No
Case Number:	CMHC Region:
In the court of County	Voluntary CSU Admission Sought: ☐ Yes ☐ No
Mobile Crisis Involvement: ☐ Yes ☐ No	

Advise the following to the *Respondent:* Information from this interview will be reported on a standardized form and submitted to the chancery court and civil commitmentexaminers. You have the right to refuse to participate. Other sources of information including a review of your legal medical records and interviews with family member and the affiant requesting commitment will be included in this report.

Respondent

Name:	DOB:	**Age: Gender: Race:**
Social Sec #: Medicaid #:		Medicare#:
Home Address:		Phone Number:
Respondent resides with minor children: ☐ Yes ☐ No		Name & Ages of Children:
Respondent resides has visitation rights to minor children: ☐ Yes ☐ No		Name & Ages of Children:
Respondent resides has legal guardian/conservator: ☐ Yes ☐ No		Name & Ages of Children:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other		

Affiant

Affiant Name:	Relation to Respondent:
Phone Number:	Home Address:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Respondent Psychosocial Information

Current Living: ☐Alone ☐Family/Friends ☐Assisted Living ☐Homeless ☐Other/Describe:

Does the Respondent currently have stable and independent living arrangements: ☐ Yes ☐ No

Housing: Dwelling: Marital Status:		Home Address:
Employed: ☐ Yes ☐ No Employer/Position:		Length of Job:
If unemployed (most recent job?):		Highest Level of Education Completed:
Religious Preference or Practice:		
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other		

Psychiatric

Current Psychotropic Medications: Dosage & Date/Time Last Taken: Is the medication helpful or problematic:

Psychiatric Hospitalizations: Has the Respondent had 2 or more psychiatric hospital or emergency admissions in the past 12 months: ☐ Yes ☐ No	Locations/Dates: Enter Location and Date
Outpatient Treatments:	Locations/Dates:
Psychological Testing:	Provider/Dates:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Medical Status & Treatment

Current Medications (not listed above):	Dosage & Date/Time Last Taken:	Is the medication helpful or problematic:
Known Medication Allergies:		

Currently Under Physician Care For:	Physician's Name:
Conditions Treated in The Past:	Provider/Dates:
Medical Hospitalization History:	Physical Disabilities:

Current Communicable Diseases:

☐ HIV/AIDS ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐TB(Tuberculosis)

☐ MRSA ☐Influenza ☐Head Lice ☐Scabies ☐Body Lice ☐STIs ☐Other

Currently Pregnant: ☐ Yes ☐ No

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Developmental Disability

History of Special Education Ruling: ☐ Yes ☐ No	If yes, describe:
Documented IQ below 70: ☐ Yes ☐ No	If yes, describe:
Documented sub-average intellectual functioning before age 18: ☐ Yes ☐ No	If yes, describe:
Documented Adaptive Functioning Deficits: ☐ Yes ☐ No	If yes, describe:

Specific Observed Adaptive Functioning Deficits:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Mental State Exam

Oriented to Date: **Time:** **Place:**
*Cue for three words (provide words)

President:

Counting Response:

Word Recall:

Completed Written Command: ☐ Yes ☐ No If no, describe:

What do you understand the reason for our meeting today to be?

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Psychiatric Symptoms Past

Respondent(R) Informant(I)

Depressive Symptoms	**R**	**I**	**Anxiety Symptoms**	**R**	**I**	**Somatic Symptoms**	**R**	**I**
☐ Depressed mood most of the day	☐	☐	☐ Worry	☐	☐	☐ Headaches	☐	☐
☐ Lack of Interest/Pleasure	☐	☐	☐ Restlessness	☐	☐	☐ Chest Discomfort/Pain	☐	☐
☐ Appetite Change or Sig Weight Change	☐	☐	☐ Easily Fatigued	☐	☐	☐ Faintness	☐	☐
☐ Insomnia (Difficulty Falling Asleep)	☐	☐	☐ Irritability	☐	☐	☐ Hot or Cold Flashes	☐	☐
☐ Feelings of Worthlessness	☐	☐	☐ Muscle Tension	☐	☐	☐ Stomach Aches/Pains	☐	☐
☐ Fatigue or Loss of Energy	☐	☐	☐ Difficulty Concentrating	☐	☐	☐ Heart Palpitations	☐	☐
☐ Diminished Concentration	☐	☐	☐ Sleep Disturbance	☐	☐	☐ Dizziness or Vertigo	☐	☐

Psychiatric Symptoms Past

Respondent(R) Informant(I)

☐ Indecisiveness	☐	☐	☐ Other	☐	☐	☐Shaking/Trembling	☐	
☐ Hypersomnia (Sleeping Excessively)	☐	☐				☐Tingling in hands or feet	☐	
☐ Recurrent Thoughts of Death	☐	☐				☐Excessive Sweating	☐	
☐ Motor Retardation	☐	☐				☐ Other	☐ ☐	
☐ Motor Agitation	☐	☐						
☐ Feelings of Hopelessness	☐	☐						
☐ Other	☐	☐						

Mania & Hypomania Symptoms	**R**	**I**		**R**	**I**
☐ At least 1 week	☐	☐	☐More talkative than usual	☐	☐
☐ 4 consecutive days < weeks	☐	☐	☐ Excessive involvement in activities with high potential for painful consequences	☐	☐
☐ Flight of ideas/racing thoughts	☐	☐	☐Distractibility	☐	☐
☐ Decreased need for sleep	☐	☐	Persistent elevated, or irritable mood and significant increases in goal directed activity ☐Yes ☐No	☐	☐
☐ Increased self-esteem of Grandiosity	☐	☐			

Thought Disorder Symptoms	**R**	**I**			
☐ Hallucinations	☐	☐	☐ Absence of emotions	☐	☐
☐ Auditory ☐Visual ☐Olfactory	☐	☐	☐Absence of speech	☐	☐
☐ Tactile ☐Gustatory	☐	☐	☐Absence of movement	☐	☐
Specific Hallucinations:	☐	☐	☐ Lack of Hygiene	☐	☐
☐ Delusions	☐	☐	☐Lack of eating/feeding	☐	☐
☐Persecutory ☐Grandiose ☐Paranoid ☐ Other	☐	☐			
Specific Delusions:					
Obsessive Compulsive Symptoms					
Obsessive Thoughts ☐Yes ☐No	☐	☐	Compulsive Behaviors ☐Yes ☐No	☐	☐
Severity: ☐Mild ☐Moderate ☐Severe	☐	☐	Severity: ☐Mild ☐Moderate ☐Severe	☐	☐
Specific Obsessions:	☐	☐	Specific Compulsions:	☐	☐

Trauma History

Trauma Exposure ☐Yes ☐No (type/approx. Date)				
Trauma Triggers:				
Environmental	☐ Crowding	☐ Room checks	☐ Confusing signs	☐ Slamming doors
	☐ Leaving bedroom door open	☐ Dark room	☐ Too hot or too cold	☐ Noise
Interpersonal	☐ Lack of privacy ☐ Confined spaces ☐ Being stared at ☐ Being approached by women	☐ Being approached by men or women ☐ Being touched ☐ Being ignored ☐ Being Teased/picked on ☐ Tall or large	☐ Arguments ☐ People too close ☐ Feeling pressured ☐ People focusing on my symptoms	☐ People Yelling ☐ Contact with Family ☐ Being ordered to do something ☐ Smells
Other Triggers	☐ Taste ☐ Time of Day	☐ sounds ☐ Sights	☐ Sensations/textures	☐ Wringing hands
Warning Signs of Emotional escalations	☐ Heart Pounding ☐ Clenching teeth ☐Bouncing legs ☐ Sweating	☐ Shortness of Breath ☐ Flushed/red face ☐Singing ☐ Rocking	☐ Breathing Hard ☐ Crying ☐ Can't sit still ☐ Pacing	☐ Wringing hands ☐ Clenching fists ☐ Cursing/swearing ☐ Giggling
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other				

Suicide Assessment

Prior Attempts:	Friend or Family Member Completed Suicide:
Approximate Date:	Approximate Date:
Method of attempt:	Method of suicide:
	Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

History or Present Danger to Self: ❒ Yes ❒ No *(If Yes, mark appropriate statement(s) below)*

❒ Thoughts of suicide	❒ Threats of suicide	❒ Plan for suicide	❒ Pre-occupation with death
❒ Suicide gesture	❒ Suicide attempts	❒ Family history of suicide	❒ Self-mutilation
❒ Inability to care for self	❒ High risk behavior	❒ Provoking harm to self from others	
❒ Other _____			
Describe: _____			

Violence Risk Assessment

Current thoughts about harming another person ☐ Yes ☐ No
If Yes, whom:
If yes, how long have you had these thoughts?
If yes, specific plan:
Access to means to carry out plan:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Violence Risk Factors Present

Present	Unknown		Present	Unknown	
☐	☐	Male sex	☐	☐	Substance Abuse
☐	☐	Suspiciousness/Perception of hidden threat	☐	☐	Comorbid MI & Substance Use Dx
☐	☐	Early offense history	☐	☐	Anger
☐	☐	Psychopathy (PCL:SV>12)	☐	☐	Antisocial Personality Diagnosis
☐	☐	Violent Fantasies	Frequency, type, recency		
☐	☐	Previous violence against other people	Frequency, severity, type		
☐	☐	Childhood physical abuse	Frequency, severity		
			Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other		

Substance Use

Do you currently use?

	Past Use	Amount	Frequency	Age of Initiation
Caffeine				
Nicotine				
Alcohol				
Marijuana				
Opioids				
Amphetamines				
Hallucinogenic				
Prescription Medication				
Over the counter medication				

History of legal charges related to substance use? ☐ Yes ☐ No	Describe:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Physical Appearance					
	Attire	**Hair**	**Nails**	**Skin**	
☐ Glasses	☐ Appropriate for occasion	☐ Clean	☐ Clean	☐ Clean	☐ Bruised
☐ Contacts	☐ Appropriate for weather	☐ Dirty	☐ Dirty	☐ Dirty	☐ Cuts/Scrapes
☐ Hearing Aids	☐ Clean	☐ Disheveled	☐	☐ Tattoos Describe:	
	☐ Dirty	☐ Styled			
	☐ Torn/worn through		☐	☐ Sores	
	☐ Other		☐		
Teeth	Unusual alterations or distinguishing features:				
☐ Clean					
☐ Dirty					
☐ Decay					
☐ Missing					
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other					

Behavioral Observations				
Motor Activity				
Diminished	Normal	Excessive	Unusual	
☐ Frozen	☐ Purposeful	☐ Restless	☐ Other	
☐ Catatonic	☐ Coordinated	☐ Squirming		
☐ Almost motionless	☐ Other	☐ Fidgety		
☐ Little animation		☐ Constant movement		
☐ Psychomotor retardation		☐ Hyperactive		
☐ Slowed reaction time		☐ Other		
☐ Other				
Speech				
Slowed	Normal	Pressured	Verbose	Unusual
☐ Minimal response	☐ Initiates	☐ Excessively wordy	☐ Over productive	☐
☐ Unspontaneous	☐ Alert/responsive	☐ Expansive	☐ Long winded	
☐ Sluggish	☐ Productive	☐ Rapid	☐ Non stop	
☐ Paucity	☐ Animated	☐ Fast	☐ Frequent run-ons	
☐ Impoverished	☐ Spontaneous	☐ Rushed	☐ Flight of ideas	
☐ Single word answers	☐ Smooth	☐ Other	☐ Hyper verbal	
☐ Other	☐ Other		☐ Other	
Thought Process				
Attention	Insight	Preoccupations		
☐ Normal	☐ Good	☐ Somatic	☐ Self	
☐ Unengaged	☐ Fair	☐ Children	☐ Finances	
☐ Distractible	☐ Poor	☐ Spouse/Sig Other	☐ Other	
☐ Hyper vigilant	☐ No insight	☐ Job		
☐ Hyper focused				
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other				

Behavioral Observations				
Affect				
☐ Flat	☐ Blunted	☐ Constricted	☐ Normal	☐ Broad
Facial Expression				
☐ Vacant				
☐ Blank				
☐ Strained				
☐ Pained				
☐ Grimacing				
☐ Smiling				
☐ Other				
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other				

Summary & Recommendations

Additional Comments:

Based on the data gathered for the current Pre-Evaluation Screening:

☐ It is **NOT** recommended that this respondent receive a civil commitment exam.

- Current available information indicates that present symptomatology is due to:
  ☐ Dementia ☐Intellectual/Developmental Disability ☐ Epilepsy ☐Chemical Dependency ☐Mental Illness

☐ It **IS** recommended that this respondent receive a civil commitment exam. Based on the data available for the current Pre-Screening Evaluation the following symptomatology cannot be managed/treated in a less restrictive environment:

1)

2)

3)

4)

** Must Complete Referral Page for appropriate supports and services for all individuals that receive a Pre-Evaluation Screening regardless of recommendation status. It is important to document that the individual was evaluated for appropriateness to the indicated intensive services and supports for current or future treatment planning.
** If the interviewer determines that there is not enough information or evidence at this time to evaluate the individual for diversion or appropriateness of referral to intensive services or supports, please notate in the comments section above.

_____
Interviewer's Signature-Credentials

_____
Interviewer's Agency

_____
County where affidavit was filed.

Referrals

Please refer to the 2021 Community Transition Guide for updated referral contact information

Respondent's County of Residence: _____

Was a referral made to a Crisis Stabilization Unit (CSU)? ☐ Yes ☐ No

Which CSU? _____

Was the Respondent accepted at the CSU? ☐ Yes ☐ No

If *No,* what was the denial reason: _____

Does the Respondent have stable and independent living arrangements?

If *No,* then refer to CHOICE Housing Program

Referral Date: _____

CHOICE Referral Staff Contact: _____

Resolution: _____

Is the Respondent currently employed?

If *No,* then refer to Supported Employment Program

Referral Date: _____

Supported Employment Staff Contact: _____

Resolution: _____

Has the Respondent had 2 or more psychiatric hospital or emergency admissions in the past 12 months? OR

Does the Respondent present with significant and major psychiatric symptoms (e.g., suicidality, psychosis) and has not benefited from traditional outpatient services?

If *Yes,* then refer to PACT or ICORT (dependent on Respondent's county of residence)

Referral Date: _____

PACT/ICORT Staff Contact: _____

Resolution: _____

Is Respondent between 15-30 years old? ☐ Yes ☐ No

Is this the Respondent's first episode of psychosis? ☐ Yes ☐ No

If the answer is *Yes* to both, then refer to NAVIGATE First Episode Psychosis Service

Referral Date: _____

NAVIGATE Staff Contact: _____

Resolution: _____