RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH

ASSESSMENT / CARE PLAN: INITIAL

Type of Plan: Medi-Cal (CARES) ☐ DPSS (ACT) ☐ CAST ☐ Walk-In: ☐ Yes ☐ No

Initial Assessment Date: ________ Provider: ______________________________ Provider #: 33 ______

Provider Phone #: ______________________ Provide Fax #: ______________________________

Consumer Name: ____
First Last

If child, caregiver/parent name: ____________________ Consumer Medi-Cal #: ______________

Consumer DOB: __________ Consumer SS#: ________________ Gender: ☐ M ☐ F

Consumer's Primary Language: ____________ Consumer's Ethnicity: ________________

Interpretation Services Offered: ☐ Yes ☐ No

Type of Living Situation: ☐ Group Home ☐ Bio Parent(s) ☐ Legal Guardianship ☐ Adopted Parent(s) ☐ Foster Home
☐ FFA (Private Foster Home) ☐ Relative Placement (Minors) ☐ Shelter Home ☐ Board & Care
☐ IMD ☐ SNF ☐ Independent Living ☐ Other ____________________

Name of Residential Facility (if Applicable): ____

Date of Placement: ________________________

Consumer's Current Address: ____

Consumer's Phone Number(s): ________________ ________________ ________________

Diagnosis: (Treatment, goals, objectives, etc must be consistent with the current diagnosis). Put a "P" next to the Primary Diagnosis.

ICD-10 Code: __________ ____
__________ ____
__________ ____

DSM: Axis I: __________ ____
__________ ____
__________ ____

Axis II: __________ ____

General Medical Conditions: ____

____

Presenting Problems Clinical Symptomology: ______________________________________

____

Consumer Name: ______________________ Social Security #: ______________

Mental Status:

Appearance	☐ Clean	☐ Well Groomed	☐ Disheveled	☐ Bizarre			
Orientation	☐ Oriented	☐ Disoriented	☐ Time	☐ Place	☐ Person	☐ Situation	
Mood	☐ Normal	☐ Anxious	☐ Depressed	☐ Angry	☐ Sad	☐ Euphoric	
Affect	☐ Appropriate	☐ Inappropriate	☐ Flat	☐ Labile	☐ Blunted	☐ Depressed	
Intelligence	☐ Average	☐ Above Average	☐ Below Average				
Memory	☐ Intact	☐ Impaired	☐ Short Term	☐ Long Term			
Attention	☐ WNL	☐ Short	☐ Impaired	☐ Preservative			
Psychomotor	☐ WNL	☐ Agitated	☐ Lethargic	☐ Retarded	☐ Catatonic		
Judgment	☐ Good	☐ Fair	☐ Limited	☐ Poor			
Insight	☐ Good	☐ Fair	☐ Limited	☐ Poor			
Speech	☐ WNL	☐ Pressured	☐ Minimal	☐ Rambling	☐ Circumstantial		
Thought	☐ WNL	☐ Concrete	☐ Disorganized	☐ Ruminative	☐ Paranoid	☐ Loose	☐ Tangential
Delusions	☐ Somatic	☐ Jealous	☐ Grandiose	☐ Persecutory	☐ Erotic	☐ None	
Hallucinations	☐ Auditory	☐ Visual	☐ Tactile	☐ Olfactory	☐ Command	☐ None	

Current Harm Assessment:

Suicide Ideation:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Suicide Intent:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Homicidal Ideation:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Homicidal Intent:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Self-Injurious Behavior:	☐ None	☐ Mild	☐ Moderate	☐ Severe

If any at present, describe type and frequency of ideation, plan, and means: ______________

Medical History: ______________

Allergies: ______________

Current Medication(s) and Dosage(s): ______________

Prescribing MD: ______________

Primary Care Physician: ______________ Date of Last Physical Exam: ______________

Drug / Alcohol Use: ☐ Present ☐ Past ☐ None Duration of Current Remission: ______________

Describe (Type, Amount, and Frequency): ______________

Current/Past Substance Use Treatment: ______________

Confidential patient information. See California Welfare and Institutions Code Section 5328

Consumer Name: ______________________ Social Security #: ______________

Prior Psychiatric Hospitalization(s)? ☐ No ☐ Yes If yes, where, when, and why: ______________

____

Prior MH Treatment: ____

Relevant Condition/Psychosocial Factors: ____

____

____

History of Mental Illness in Family: ☐ No ☐ Yes If yes, describe: ______________

Occupation: ______________ Functioning: ______________

School: Education Level: ______ Functioning / Grades: ______________

Client Strengths: ____

MEDICAL NECESSITY: Describe specifically how symptoms impair a specific area of functioning; i.e.: work, school, health/safety, social. (For children there must be a reasonable probability/risk of significant deterioration in an important area of life functioning). **USE CURRENT DSM CRITERIA WHEN POSSIBLE**:

____

____

Dysfunction Rating: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Recommendations (Reasons for continued treatment/expected duration of treatment):

____

____

PROPOSED TREATMENT: ** For providers requesting authorization through CARES only.

Refer for Psychiatric Services: ☐ Yes ☐ No If yes, need to complete a "Provider Referral Request Form"

Refer for Therapy: ☐ Yes ☐ No

Psychiatric Evaluation/Medication Management: _____ minute session(s) per ☐month / ☐quarter for _____ ☐weeks / ☐months

Individual Therapy: ______ session(s) per ☐week / ☐month / ☐quarter for ____ ☐weeks / ☐months (☐15 / ☐30 / ☐60 / ☐90 mins)

Group Psychotherapy: ______ session(s) per ☐week / ☐month ____ ☐weeks / ☐months

Family Therapy: ______ session(s) per ☐week / ☐month / ☐quarter for ____ ☐weeks / ☐months (☐30 / ☐60 minutes)

Collateral: ______ session(s) per ☐week / ☐month / ☐quarter for ____ ☐weeks / ☐months (☐30 / ☐60 minutes)

With: ______________ Purpose: ______________________________

Outpatient Consultation with: ______________________________

Purpose: ____

Consumer Name: ______________________________ Social Security #: __________________

GOALS: Must be related to the specific impairment(s) listed above. Must be measurable/observable, and must include current frequency of the behavior, and the desired frequency.

Behavior Outcome/Goal #1: ______________________________

____

Target Date to Meet Goal #1: ______________

Provider Intervention (Be Specific): ______________________________

____

Consumer Will (Be Specific): ______________________________

____

Behavior Outcome/Goal #2: ______________________________

____

Target Date to Meet Goal #2: ______________

Provider Intervention (Be Specific): ______________________________

____

Consumer Will (Be Specific): ______________________________

____

Provider's Signature and License	Date
Provider's Printed Name and Discipline	Date
Clinical Supervisor's Signature and License	Date
Consumer's Signature	Date
Parent/Guardian's Signature	Date

Consumer offered a copy of Care Plan? ☐ Yes ☐ No *Consumer received copy of Care Plan?* ☐ Yes ☐ No ______ Date

Consumer Received Riverside County's Informing Material ______________ Date