

A. PREADMISSION FACE SHEET

1. PERSONAL INFORMATION

Name: _____ DOB: _____ Age: _____
First Middle Last

Address: _____
Street City State Zip code County

SSN: _____ - _____ - _____ Gender: _____ Race: _____ Hispanic origin? _____
(Optional)

Primary language: _____ Height _____ Weight _____ Hair Color _____ Eye Color _____

Phone: (____) _____ Marital status: Never married Married Separated Divorced Widowed

Military Status: _____ VA contacted: No Yes (_____)
Name Phone

2. PREADMISSION SCREENING ENCOUNTER INFORMATION

Date: _____ Evaluation start time: _____ Evaluation end time: _____ Location: _____

Referral Source: _____ Evaluating CSB/BHA: _____ Consumer ID# _____

CSB of Residence: _____ CSB Code #: _____ Contacted?: No Yes (_____)
Name Phone

REACH program contacted: N/A No Yes (_____)
Name Phone

Petitioner Name/Contact Information: _____

ECO: No Yes: Magistrate issued Law enforcement initiated; Date/Time ECO Executed: _____

Disposition: Release Referral Safety Plan CSU Voluntary Recommitment TDO

Other _____ Psych Bed Registry Query # _____ Facility: _____
Case/TDO # _____ If change of facility, name of new facility: _____

3. CONTACT INFORMATION & COLLATERAL SOURCES (including health care agent(s))

Name: _____ Relationship: _____ Phone: (____) _____

Address: _____
Street City State Zip code County

Name: _____ Relationship: _____ Phone: (____) _____

Address: _____
Street City State Zip code County

Source(s) of
Medical
History,
Medication,
& Collateral
Information

- Person
- Family member (name and relationship): _____
- Others (e.g., medical staff, law enforcement): _____
- Medication containers
- Medical records (specify): _____
- Collateral sources were unavailable >> **Explain:** _____

4. HEALTHCARE INFORMATION AND MEDICAL HISTORY

Advance Directive: No Yes Unknown If yes, obtained? No Yes

If not obtained, location: _____

If obtained, AD includes: Medical Mental health End-of-life

Insurance: Medicaid Medicare None Other: _____ Unknown

First plan # _____ If applicable, second plan #: _____

Income: SSI SSDI Unknown

Medical History and current medical issues (*If checked, see attached medical information*)

Allergies(including food) or adverse side effects to medications: Yes No Unknown

If yes, explain:

Is the person pregnant? Yes No Unknown N/A

Current Medications: No Yes *If checked, see attached medication list*

Name	Dose	Schedule	Prescriber

Recent medication change? Unknown No Yes >> Explain:

5. LEGAL STATUS

Code value: _____

Details:

Contact Person:

B. RISK ASSESSMENT DETAILS

1. REASON FOR REFERRAL

2. CURRENT AND HISTORICAL RISK INDICATORS

>> Suicidal Ideation/Behavior: Screen for Current and Historical <<

Current & Historical Thoughts and Means	Comments (details for each item that is applicable, including timeframe)	None known/ reported
Suicidal Thoughts		<input type="checkbox"/>
Suicide Plan		<input type="checkbox"/>
Suicidal Intent		<input type="checkbox"/>

Person evaluated: _____

Access to Means		<input type="checkbox"/>
Self-Harm		<input type="checkbox"/>
Suicide Attempt(s)	(including if attempt was stopped by someone or something, or attempt made when others around)	<input type="checkbox"/>

Additional information, if applicable. *(In cases where the risk assessment cannot be completed, you may document the reason(s) here.)*

>> Physical Harm Ideation/Behavior: Screen for Current and Historical <<

Current & Historical Behavior	Comments (details for each item that is applicable, including ability to carry out thoughts/plans and timeframe)	None known/ reported
Threats; thoughts or plans to harm		<input type="checkbox"/>
Expressions of aggression or anger		<input type="checkbox"/>
Fight or attempted fight		<input type="checkbox"/>
Other:		<input type="checkbox"/>
Past physical harm ideation/behavior		<input type="checkbox"/>

Additional information, if applicable. *(In cases where the risk assessment cannot be completed, you may document the reason(s) here.)*

>> Inability to Care for Self: Screen for Current and Historical <<

Evidence of decreased ability to provide for basic needs and/or protection as a result of mental illness:
 None known/reported Unable to seek basic nourishment Unable to seek shelter (not just lack of access)
 Clothing unsuitable for weather Recklessness (spending, safety) Serious neglect of hygiene/ADL's
 Serious neglect of medical care Other:

Comments:

**For minors, ability to care for self is defined in terms of what would be expected for a minor of a similar age and inability is evidenced by delusional thinking or a significant impairment of functioning hydration, nutrition, self-protection, or self-control.*

3. OTHER HISTORICAL RISK FACTORS

Evidence of Impulsivity/Self-Control

Behavior	Comments (details for each item that is applicable)	None known/ reported
Non-suicidal self-injury		<input type="checkbox"/>
Reckless behavior		<input type="checkbox"/>
Difficulty following through with safety plans		<input type="checkbox"/>
Revocation/violation of probation, supervised release, or other such supervision		<input type="checkbox"/>
Did not follow recommended treatment plan (e.g., MOT, outpatient)		<input type="checkbox"/>

Substance Use Assessment

No current use reported No history of use reported Historical use *only* Declined to answer

Drug	Frequency	Amount	Method	Last Use Date	Age of 1 st Use

History of significant withdrawal symptoms:

Seizures DTs Other: _____

Lab Results:

Blood alcohol level: _____ Toxicology screen: _____

Other Risk and Historical Factors

None known/reported Family or peer suicide Childhood abuse/neglect
 Other trauma: _____
 Recent discharge from inpatient psychiatric (within last 60 days) Owns or has access to firearm
 Other:

4. PSYCHIATRIC TREATMENT

Is the person currently in treatment? Yes No Unknown

If yes: Name of facility/provider: _____

Date treatment began: _____ Frequency of treatment: _____

History of treatment? Yes No Unknown

If yes, list most recent providers/facilities, type of treatment, and dates of service:

Provider or Facility	Treatment type (e.g., outpatient, inpatient, detox)	Dates of service

History of treatment...

with psychiatric medication? Yes No Unknown

in state hospital? Yes No Unknown (name and date: _____)

in a crisis stabilization unit? Yes No Unknown (name and date: _____)

Does the person express treatment preferences? Yes No Unknown

If yes, the person's preferences are:

5. CURRENT SYMPTOMS AND MENTAL STATUS

Diagnosis (ICD-10; (P) for provisional, (H) for historical)

Symptoms (Check all that apply)

- High anxiety, stress, emotional pain
- Hopelessness
- Anger
- Feeling burdensome to others
- Negative appraisal of illness or recovery
- Social withdrawal
- Increased depressive symptoms

Capacity (For adults and minors age 14 and older)

- The individual appears to have capacity to consent to voluntary psychiatric admission because able to:
 - Maintain and communicate choice,
 - Understand relevant information, and
 - Understand consequences
- The individual appears to lack capacity

Mental Status (Check all that apply)

Appearance	<input type="checkbox"/> WNL	<input type="checkbox"/> unkempt	<input type="checkbox"/> poor hygiene	<input type="checkbox"/> tense	<input type="checkbox"/> rigid	<input type="checkbox"/> other:
Motor	<input type="checkbox"/> WNL	<input type="checkbox"/> psychomotor retardation	<input type="checkbox"/> psychomotor agitation	<input type="checkbox"/> tremor	<input type="checkbox"/> restless	<input type="checkbox"/> other:
Behavior	<input type="checkbox"/> WNL <input type="checkbox"/> tearful	<input type="checkbox"/> agitated <input type="checkbox"/> easily startled	<input type="checkbox"/> guarded <input type="checkbox"/> other:	<input type="checkbox"/> manic	<input type="checkbox"/> distracted	<input type="checkbox"/> impulsive
Orientation	<input type="checkbox"/> WNL	<input type="checkbox"/> time disorientation	<input type="checkbox"/> place disorientation	<input type="checkbox"/> person disorientation	<input type="checkbox"/> situation disorientation	<input type="checkbox"/> other:
Speech	<input type="checkbox"/> WNL <input type="checkbox"/> slurred	<input type="checkbox"/> pressured <input type="checkbox"/> other:	<input type="checkbox"/> slowed	<input type="checkbox"/> soft	<input type="checkbox"/> loud	<input type="checkbox"/> incoherent
Mood	<input type="checkbox"/> WNL <input type="checkbox"/> withdrawn	<input type="checkbox"/> depressed <input type="checkbox"/> anhedonic	<input type="checkbox"/> angry <input type="checkbox"/> other:	<input type="checkbox"/> hostile	<input type="checkbox"/> euphoric	<input type="checkbox"/> anxious
Affect	<input type="checkbox"/> WNL <input type="checkbox"/> other:	<input type="checkbox"/> constricted	<input type="checkbox"/> blunted	<input type="checkbox"/> flat	<input type="checkbox"/> labile	<input type="checkbox"/> incongruent with situation
Thought Content	<input type="checkbox"/> WNL <input type="checkbox"/> obsessions	<input type="checkbox"/> impaired <input type="checkbox"/> grandiose	<input type="checkbox"/> unfocused <input type="checkbox"/> phobias	<input type="checkbox"/> preoccupied <input type="checkbox"/> ideas of reference	<input type="checkbox"/> delusions <input type="checkbox"/> paranoid	<input type="checkbox"/> thought insertion <input type="checkbox"/> other:
Thought Process	<input type="checkbox"/> WNL <input type="checkbox"/> impaired concentration	<input type="checkbox"/> illogical <input type="checkbox"/> circumstantial	<input type="checkbox"/> concrete <input type="checkbox"/> loose associations	<input type="checkbox"/> incoherent <input type="checkbox"/> flight of ideas	<input type="checkbox"/> tangential <input type="checkbox"/> thought blocking	<input type="checkbox"/> perseverative <input type="checkbox"/> other:
Sensory	<input type="checkbox"/> WNL	<input type="checkbox"/> hallucinations type: _____		<input type="checkbox"/> illusions	<input type="checkbox"/> flashbacks	<input type="checkbox"/> other:
Memory	<input type="checkbox"/> WNL <input type="checkbox"/> other:	<input type="checkbox"/> impaired immediate		<input type="checkbox"/> impaired recent	<input type="checkbox"/> impaired remote	
Appetite	<input type="checkbox"/> WNL	<input type="checkbox"/> decreased	<input type="checkbox"/> increased	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain	<input type="checkbox"/> other:
Sleep	<input type="checkbox"/> WNL	<input type="checkbox"/> insomnia	<input type="checkbox"/> onset problem	<input type="checkbox"/> maintenance problem	<input type="checkbox"/> hypersomnia	<input type="checkbox"/> other:
Insight	<input type="checkbox"/> WNL	<input type="checkbox"/> some	<input type="checkbox"/> little	<input type="checkbox"/> none	<input type="checkbox"/> blaming	<input type="checkbox"/> other:
Judgment	<input type="checkbox"/> WNL	<input type="checkbox"/> impaired	<input type="checkbox"/> poor	<input type="checkbox"/> other:		

Is there a prior episode of psychosis? No Unknown Yes (if yes, describe in Mental Status Narrative)
Is the person showing symptoms of psychosis? No Yes (if yes, describe in Mental Status Narrative)

Mental Status Narrative (description of symptoms checked above):

Engagement, Reliability, Response to Interviewers

Person's report appears reliable and consistent. Yes No

Engaged and cooperative with assessment and treatment planning. Yes No

Comments (optional):

6. FEASIBILITY OF LESS RESTRICTIVE ALTERNATIVES

	Yes	No	N/A
Suicide			
Available resources are sufficient to address immediate suicide risk and person-specific triggers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Harm			
Available resources are sufficient to address immediate risk of physical harm and person-specific triggers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to care for self and basic needs			
Available resources are sufficient to improve person's ability to care for self and basic needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Plans for addressing risk in the community -or- Rationale why less restrictive alternatives not feasible

(If checked, see attached safety plan):

C. PREADMISSION SCREENING SUMMARY

1. PRESENTING SITUATION

Summary of presenting crisis (including person and collateral perspectives):

The person's most significant stressors:

Coping strategies already attempted by the person:

Strengths or moderating factors related to documented risk issues and/or concerns:

Assessment and disposition recommendation summary (including person-specific triggers that could quickly increase risk for suicidal or physical harm or quickly decrease ability to care for self and basic needs, and any available resources or protective factors):

D. CSB RECOMMENDATIONS

ADULT - As a result of the emergency evaluation:

The CSB finds that the person meets / does not meet the civil commitment criteria, and the CSB recommends:

- No further action at this time
- Voluntary community treatment (if known at time of disposition, facility/provider: _____)
- Voluntary admission to a crisis stabilization program at _____
- Voluntary inpatient treatment
- Temporary detention order
- Recommitment

The CSB further recommends:

- Consideration of 10-day inpatient admission by health care agent or guardian consent
Agent or guardian name: _____
- Alternative transportation by _____

MINOR - As a result of the emergency evaluation, the CSB recommends:

The CSB finds that the minor meets / does not meet the civil commitment criteria, and the CSB recommends:

- No further action at this time
- Voluntary community treatment (if known at time of disposition, facility/provider: _____)
- Voluntary admission to a crisis stabilization program at _____
- Voluntary inpatient treatment
- Temporary detention order

The CSB further recommends:

- Alternative transportation by _____
- An order directing either or both parents/guardian to comply with conditions relating to minor's treatment

E. NOTIFICATIONS

1. Attempt to obtain person's agreement or objection to legally required notifications

(per Va. Code § 32.1-127.1:03(D34))

_____ will be contacted with information directly relevant to their involvement with the person's health care, including location and general condition.

Person agrees Person objects Person lacks capacity Emergency makes impractical to agree/object

2. Required notification to family member or personal representative, including agent in healthcare advance directive

(per Va. Code §§ 16.1-337 or 37.2-804.2)

Contact was made with _____ via _____

Reasonable attempt was made to contact _____ via _____

Comments:

No notification made because

Notice already provided, or Contact is prohibited by court order, or Consent is not available and contact is not in person's best interest, or Person has capacity and objects

3. Required notification when TDO is not recommended for an adult

(per Va. Code §37.2-809)

The evaluator informed

the petitioner (_____),

the onsite treating physician (_____), and

the person who initiated emergency custody (_____); or check here if the person was not present).

Person who initiated emergency custody was informed that CSB would facilitate communication with the magistrate upon request

Person who initiated emergency custody requested to speak with magistrate regarding recommendation, so evaluator made arrangements

Preadmission screening clinician signature

Date

CSB/BHA

Printed name (Not required if electronically signed)

Preadmission screening clinician signature

Date

CSB/BHA

Printed name (Not required if electronically signed)

F. CSB Report to Court and Recommendations for the Individual's Placement, Care, and Treatment

Name: _____ Date: _____ Time: _____ am pm

- No further treatment required.
- Has / Does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for outpatient treatment).
- Is / Is not willing to be treated voluntarily (N/A under Virginia Code § 19.2-169.6).
- Voluntary community treatment at the CSB (_____) or other (_____).
- Voluntary admission to a crisis stabilization program (_____).
- Adult:** Voluntary inpatient treatment because individual requires hospitalization and has indicated that he/she will agree to a voluntary period of up to 72 hours and will give the facility 48 hours' notice to leave in lieu of involuntary admission.
- Minor:** Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older.
- Minor:** Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

Minor 16.1-340.4 Under age 14 Age 14 or older
 (For inpatient treatment only) Parent or guardian is / is not willing to consent to voluntary admission.

Because of mental illness, meets the criteria for involuntary admission or mandatory outpatient treatment as follows:

- The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats, or The minor is experiencing serious deterioration of his ability to care for himself in a developmentally age appropriate manner, evidenced by: delusional thinking or significant impairment of functioning in hydration nutrition self-protection self-control.
 - The minor is in need of compulsory treatment for mental illness and is reasonably likely to benefit from the proposed treatment.
- The parent or guardian with whom the minor resides is willing to approve any proposed commitment.
 Yes No Unavailable If no, such treatment is necessary to protect the minor's life, health, safety or normal development. Yes No

Therefore, the CSB recommends:

- Involuntary admission and inpatient treatment, as there are no less restrictive alternatives to inpatient treatment.
 Alternative transportation provided by: _____
- Mandatory outpatient treatment (16.1-345.2) not to exceed 90 days because less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and determined to be appropriate; and providers of the services have agreed to deliver the services. The minor, if 14 years of age or older, and his parents or guardians have sufficient capacity to understand the stipulations of the minor's treatment, have expressed an interest in the minor's living in the community and have agreed to abide by the minor's treatment plan, and are deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services. And the ordered treatment can be delivered on an outpatient basis by the CSB or a designated provider(s) (_____).
- The best interests of the minor require an order directing either or both of the minor's parents or guardian to comply with reasonable conditions relating to the minor's treatment. Yes No

Adult 37.2-816

Because of mental illness meets the criteria for involuntary admission or mandatory outpatient treatment* as follows:

- There is a substantial likelihood of serious physical harm to self or others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any, or
- There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to lack of capacity to protect him/herself from harm or to provide for his/her basic human needs*

Therefore, the CSB recommends:

- Involuntary admission and inpatient treatment as there are no less restrictive alternatives to inpatient treatment.
 Alternative transportation provided by: _____
- Mandatory outpatient treatment (37.2-817(D)) because less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and are deemed to be appropriate; and the person has agreed to abide by his/her treatment plan and has the ability to do so. The recommended treatment is actually available on an outpatient basis by the CSB or designated provider(s) (_____).
- Physician discharge to mandatory outpatient treatment following inpatient admission pursuant to 37.2-817(C1)&(C2). The person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission; in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent relapse or deterioration of his condition that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment; and the person is likely to benefit from mandatory outpatient treatment.

Preadmission screening clinician signature Date

Preadmission screening clinician signature Date

Print name here (Not required if electronically signed) CSB/BHA

Print name here (Not required if electronically signed) CSB/BHA

*Not applicable under Virginia Code 19.2-169.6

Person evaluated: _____