**Identifying Information:**

Student Name: Click or tap here to enter text.

Student ID: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Referred By: Click or tap here to enter text.

Date of Assessment: Click or tap to enter a date.

**Informed Consent:**

Was the student advised that mental health services are voluntary and of the limits to confidentiality?

Yes  No

**Documents Reviewed:**

SIF  ETA 653  Health History Form (HHF)  Physical Examination (PE)  Other

**Reason for Referral:**  **Referral form included?**  Yes No

Click or tap here to enter text.

**Relevant Psychosocial History** (Family history of mental illness/substance abuse, cultural factors, academic history, spiritual/religious history, legal history, trauma history, abuse history as victim or perpetrator) **[Include relevant information from interview, records, and SIF]:**

Click or tap here to enter text.

**Mental Health Treatment History** (outpatient or inpatient treatment, previous counseling; **was it helpful?**):

Click or tap here to enter text.

**Psychotropic Medications** (current and previous): None

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication/Dose and Frequency** | **Indication** | **Now** | **Past** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Substance Use History:**  No  Yes (explain below)  TEAP Involvement

Click or tap here to enter text.

**Relevant Medical History** (Current and previous significant health conditions, hospitalizations. Include relevant information from HHF and PE)**:**

Click or tap here to enter text.

**High Risk Screening:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Suicidal Ideation:** | | Yes  No |  |
|  | If yes, is there a plan? | Yes  No | If yes, explain:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Is there intent? | Yes  No | If yes, explain:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Self-Injurious Behaviors:** | | Yes  No | If yes, explain:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Homicidal Ideation:** | | Yes  No | If yes, explain:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Other Significant Risk Screening Findings** (e.g. previous suicidal/homicidal ideation, previous self-injury, thrill seeking behaviors, history of assault and/or violence):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Rapport** | **Mood** | **Affect** | **Speech** | **Behavior** | **Thought Content** | **Insight/Judgment** |
| Cooperative  ☐ Avoidant  Apathetic  ☐ Dismissive  Evasive  Guarded  Hostile  Mistrustful  ☐ Resistant | Euthymic  Depressed  Anxious  Angry  Irritable  Euphoric  Expansive  ☐ Labile | Full range  Congruent  Incongruent  ☐ Blunted  Constricted  Flat  Expansive  Labile | WFL  Mumbling  Pressured  Excessive  ☐ Rapid rate  ☐ Slow rate  ☐ Halting  ☐ Loud  Soft  Monotone | Appropriate  Anxious/tense  Restless  Hyperactive  Impulsive  Agitated  ☐ Withdrawn  ☐ Lethargic  ☐ Compulsive  ☐ Passive  ☐ Histrionic | Logical/coherent  Concrete  Disorganized  Perseverative  Tangential  Loose associations  ☐ Word salad  ☐ Paranoia  ☐ Bizarre/delusional  ☐ Dissociation | Age-appropriate  Fair  Poor (Based  on history  and/or  observation) |

**Current Mental Status (check all that apply):**

**Evidence-Based Screening Tools** (*Place the signed and dated screening tool with the Intake Assessment in the Mental Health section of the Student Health Record):*

**​**☐ None Administered

|  |  |  |
| --- | --- | --- |
| **Screening Tool** | **Score** | **Interpretation** |
| ​​Choose an item.  If other, explain: | Click or tap here to enter text. | Click or tap here to enter text. |
| Choose an item.  If other, explain: | Click or tap here to enter text. | Click or tap here to enter text. |

**Diagnostic Impression(s):**

|  |  |  |
| --- | --- | --- |
| **Diagnostic Code** | **Descriptor** |  |
| **Primary:** | Click or tap here to enter text. | ☐ None ☐ Provisional ☐ Rule Out |
| **Secondary:** | Click or tap here to enter text. | ☐ None ☐ Provisional ☐ Rule Out |

**Brief Clinical Summary:**

Click or tap here to enter text.

**Mental Health Treatment Plan** (Check proposed follow-up services, and/or referrals):

Is the student interested in services or follow-up at this time?  Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical Follow-up/Educational Intervention** | | | |
|  | Student will have follow-up appointment with CMHC to address identified concerns and develop specific coping strategies. Issue/ Behavior/Symptoms to be addressed:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Follow-up date:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Student provided educational information (e.g., sleep hygiene, stress management, etc.). |
| **Referrals** | | | |
|  | Student will be referred to off center mental health services. Reason(s) for referral:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **TIP: Remember to use the** [**Off-Center Appointment Verification and Feedback**](https://supportservices.jobcorps.gov/health/Documents/Off_Center_Appointment_Verification_Form_Mar2020.docx) **form and file in SHR.** |  | Student will be referred to counselor for personal counseling to address the following identified concerns and case management:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | CMHC will contact referring staff to verbally discuss student and specific behavior strategies. **Document contact and strategies discussed in SHR.** |  | Student will be referred to other HWC staff for follow-up (e.g., center physician, TEAP/TUPP specialist, HEALs Program). |
|  | Student will be referred to the following center support group(s):  Anger management  Stress Management  Handling relationships  Coping Skills  Mood regulation  Other/s: |  | Student will be referred to Disability Coordinator for consideration of reasonable accommodations and/or follow-up. |
|  | Other: |  |  |
| **Leave/Medical Separation with Reinstatement (MSWR) if applicable** | | | |
|  | Student is considered for leave.  Type of leave:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Document reason(s) for leave in SHR.** |  | Student is considered for MSWR . **Document reason(s) for MSWR in SHR. Collaborate with HWD to complete the MSWR Form to be given to the student.** |

**Signatures**

Click or tap here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap to enter a date.

Evaluator, Name, Title and Credential Signature Date

Licensed Supervisor (if applicable) Signature Date