



Clinical/ Psychiatric Assessment

MENTAL HEALTH SERVICES

This form may be used for clients of any age.

NAME / MRN _____

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Service Date: _____

Service Category:

CPT/HCPC Service Provided Lockout - CPT/HCPC Service Provided

Other Nonbillable Service Provided:

Money Management Providing transportation Leaving voicemails

Coordination of logistics Clerical work Other _____

Direct Service Time (Min): _____

Documentation Time (Min): _____

Travel Time (Min): _____

Number in Group: _____

CPT/HCPC Code: _____

Location of Service (Please check one)

- Age-Specific Community Center
- Client's Job Site
- Correctional Facility
- Faith-Based
- Field
- Health Care/Primary Care
- Home
- Nontraditional Location
- Homeless/Emergency Shelter
- Inpatient
- Mobile Service
- Non-Traditional service location
- Office
- Other Community Location
- Phone-provided in client's home
- Other _____
- Phone-provided other than in client's home
- Residential Care - Adults
- Residential Care - Children
- School
- Telehealth/Video-provided in client's home
- Telehealth/Video-provided other than in Client's home
- Unknown/Not Reported
- Unknown

Did this service involve interactive complexity? Yes No

Did this service include the interpretation of results and explanation to the client/family? Yes No

For Clients Under 21 only:

Is this an ICC Service? Yes No

Is this service linked to a Child and Family Team? Yes No

COUNTY STAFF ONLY: Does this service fall under FFPSA (Qualified Individual? Yes No

Was an Interpreter used? Yes No Name of Interpreter: _____

Language

Language service provided in other than English: Spanish Other _____

Is the client pregnant? Yes No (If yes, please document how service was pregnancy-related)

EBP/Service Strategies:

- Assertive Community Treatment
- Supportive Employment
- Supportive Housing
- Family Psychoeducation
- Integrated Dual Diagnosis Treatment
- Illness Management and Recovery
- Medication Management
- New Generation Medications
- Therapeutic Foster Care
- Multisystemic Therapy
- Functional Family Therapy
- Peer/Family Delivered Services
- Psychoeducation
- Family Support
- Supportive Education
- In Partnership w/ Law Enforcement
- In Partnership w/ Health Care
- In Partnership w/ Social Services
- In Partnership w/ SA Services
- Integrated Services for MH/Aging
- Integrated Services for MH/DD
- Ethnic-Specific Service Strategy
- Age-Specific Service Strategy
- Unknown Service Strategy

NAME / MRN _____

Evidence-based practice/tracking program? Yes No Program _____

This service was provided via telehealth with the consent of the client or authorized representative.

Referred By: _____

Identifying Information

Legal Name: _____ Age: _____ DOB: _____

Preferred Name: _____

Gender:

Male Female Transgender F-M Transgender M-F Nonbinary Other _____

Marital Status:

Single Married Divorced Partnered Widowed

Address: _____

Phone #: _____

Emergency Contact: _____
Name Phone number

Client Information

Entitlements: M/C Medicare BHC Other Health Care Info _____
 No Health Insurance Coverage
 SSI SSDI Payee: _____

Monthly Income _____ Refer to a Financial Counselor? Yes No

Living Situation Independent Living Immediate Family Extended Family Shared Housing
 Board & Care Residential Care Facility **Homeless** Other

Support System Contacts: _____

Other Agencies Involved:

CC Provider Network CFS/APS Voc Services
 AOD Regional Center Homeless Services

Other _____

Presenting Problem: What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms, and functional impairment.

Functional Impairments:

Mental Status Examination: (appearance, mood, affect, attitude, thought process and content, sensorium, attention, memory, insight)

Trauma History

Exposure and Stress Reaction

Behavioral Health and Treatment History: (Past mental health conditions; inpatient/outpatient treatment; psychiatric medications)

Substance Use: (Use and related problems over the past 12 months. If an Initial assessment, full history)

Medical History/Allergies/Medications:

Psychosocial Factors: (Relevant family background, current family information, living situation, social support, work and school, cultural and linguistic factors, sexual orientation, and gender identity)

Strengths, Criminal Justice History, Risk Assessment:

Clinical Summary: (including whether client meets medical necessity for specialty mental health services)

Current Diagnosis:

Primary
ICD-10 Code: _____ DSM-5 Narrative: _____

Secondary
ICD-10 Code: _____ DSM-5 Narrative: _____

Recommendations, Plan, Referrals:

NAME / MRN

Is this late documentation? Yes No

Staff Signature/License

Printed Name

Date

Co-Signature of Licensed Clinician

Printed Name

Date

Data Entry Clerk Initials