Centralized Assessment Team - Evaluation Form

Evaluation Date:____/____/______ Time Call Received: ________ am / pm

No Clinician Available: Caller Referred to Emergency Services: ☐ No Contact Made: ☐ NON-URGENT ☐

Referral Sourc

Callers Name: ____________________ Callers Phone Number: (____) ______-________

Relationship to Client: ____________________ Destination Address: ____________________

Referral Source Category: ____________________ Referral Source: ____________________

Summary of Problem: ____________________

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Client Informat and History

Client First Name: ____________________ Client Last Name: ____________________

Client Address: ____________________ City: ____________________

Client Phone Number: (____) ______-________ MRN: ____________________ SSN: ____________________

Gender: M / F / Other DOB:____/____/______ Marital Status: ____________________

Ethnicity: ____________________ Funding Source: ____________________

Primary Language: ____________________ Income Source: ____________________

Suicidal: ☐ Previous Suicide Attempts: ☐ Previous Attempts: ____________________

Risk of Violence: ☐ Weapons on Person: ____________________ Targeted Victim: ____________________

Currently Intoxicated: ☐ Means of Intoxication: ____________________

Alcohol and Drug Abuse Problems: ____________________

Last Use of Substance: ____________________ Amount Used: ____________________

History of Mental Illness: ____________________

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Prior Psychiatric Hospitalizations: ☐ Prior Hospitalizations: ____________________

Medical Issues: ____________________

Medications: ____________________ Prescribed By: ____________________

Medical Clearance Needed: ☐ Clearance Provided By: ____________________

Clinic Response

Primary Clinician: ____________________ Secondary Clinician: ____________________

Day of Week: ____________________ Holiday: ☐ Shift: ____________________ Evaluation City: ____________________

Hospitalized or Diverted: ____________________ Hosp/Diverted At: ____________________

1. Clinician Contacted: ____________________ am / pm
2. Clinician Dispatched: ____________________ am / pm
3. Arrival at Destination: ____________________ am / pm
4. Assessment Begins: ____________________ am / pm
5. Assessment Ends: ____________________ am / pm
6. Response Time in minutes: ____________________