CHOICES

Initial Screening

Date/Time of Referral:	
Referral Source Facility/Phone #:	ACT Staff Member:

Client's name:		**D.O.B.** ☐ Male ☐ Female	
Client currently Homeless:	☐ Yes ☐ No	Client's current location:	Client's Contact #:
Guardian:	☐ Yes ☐ No	Guardian Name:	
Agency:		Guardian Contact #:	
Client's diagnosis:			
Pertinent HX/Psychosocial Crisis:			
Any current medical conditions:			
Current Medications:			

Substance abuse concerns:	☐ Yes	☐ No	If yes explain:
Any signs of substance dependency:	☐ Yes	☐ No	If yes explain:
Any recent drug screens completed:	☐ Yes	☐ No	If yes explain:
Substance of choice:			

Willing to participate in case management 2-3 times/wk?	☐ Yes	☐ No
Has been notified of "no weapons in home" policy?	☐ Yes	☐ No
Willing to take medications?	☐ Yes	☐ No

Willing/able to participate in voc rehab & SA services as needed?	☐ Yes	☐ No	If yes explain:
Does client require assistance with personal care?	☐ Yes	☐ No	If yes explain
Difficulty with ADL's:	☐ Yes	☐ No	If yes explain:
Current medical issues:	☐ Yes	☐ No	If yes explain:
Hx of unsafe behaviors towards others physical/sexual:	☐ Yes	☐ No	If yes explain:
Hx of arson:	☐ Yes	☐ No	If yes explain:

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Sex offender:	☐ Yes	☐ No	If yes explain:
Safety Issues:	☐ Yes	☐ No	If yes explain:
Current Legal Issues/P.O.	☐ Yes	☐ No	If yes explain:
Psychosis:	☐ Yes	☐ No	If yes explain:
Agitation:	☐ Yes	☐ No	If yes explain:

Has client had any hospitalizations? If so, how many and explain circumstances:

Any recent admissions to Psych ER, CRC, or API?

More recent progress notes/labs needed: ☐ Yes ☐ No

☐ Accepted ☐ Declined ☐ Deferred

Signature: _____

Plan of Action: _____

Notes:

Follow Up:

Signature: _____